A CRITICAL EVALUATION OF THE SECTOR WIDE APPROACH (SWAp) IN THE HEALTH SECTOR IN ZAMBIA

by

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DECLARATION

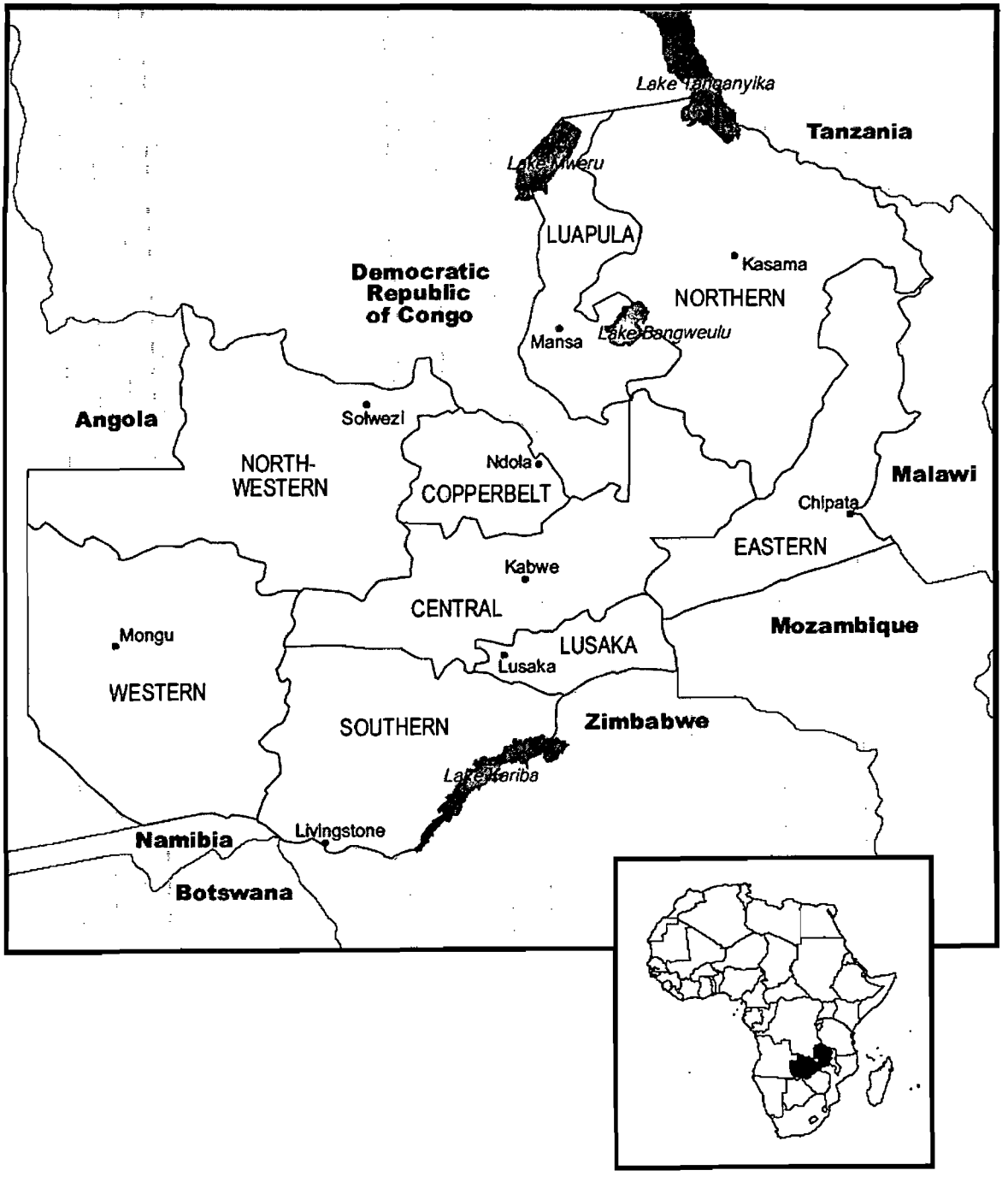
This thesis in its original form is entirely mine and has never been submitted to this University or any other institution of higher learning for any award. It is a product of my original work and the study was done in Zambia between November 2005 and June 2006. Other sources of data are fully acknowledged and referenced.

Signed by candidate

Collins Chansa

Date: 1st June 2006

ZAMBIA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LUSAKA
Lusaka
WESTERN
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Zimbabwe
Lake Kariba
Namibia
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Botswana

DEDICATION

This dissertation is dedicated to my late brothers Norman and Moses Chansa. You are fondly missed and things will never be the same without you. In earnest, loved ones never really depart and at every moment, your memories are still very much with me.

M.Y.S.R.I.P

Health Reforms: The Zambian Dream

"I think the Zambian idea of health reforms was a good dream. I think that it needed dedication, I know that it's been difficult but it's still a useful dream....let it live on....let us push it forward, we are all beneficiaries of good dreams"
(Katele Kalumba, 2003).

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Furthermore, I would like to acknowledge the works of earlier authors on the subject matter for inspiring the study.

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ACRONYMS

AfDB	-	African Development Bank
AIDS	-	Acquired Immuno Deficiency Syndrome
ARVs	-	Anti-Retroviral
BHCP	-	Basic Health Care Package
CBoH	-	Central Board of Health
CDE	-	Classified Daily Employees
CHAZ	-	Churches Health Association of Zambia
CoC	-	Code of Conduct
CIDA	-	Canadian International Development Agency
CPs	-	Cooperating Partners
DANIDA	-	Danish International Development Agency
DCI	-	Development Cooperation Ireland
DFID	-	Department for International Development
DGIS	-	Director General International Co-operation (Dutch Aid)
DHMT	-	District Health Management Team
DILSAT	-	District Integrated Logistic Self-Assessment Tool
ECSAFA	-	Eastern, Central and Southern African Federation of Accountants
EU	-	European Union
FAMS	-	Financial and Administrative Management System
GDP	-	Gross Domestic Product
GFATM	-	Global Fund for fight against AIDS, Tuberculosis and Malaria
GRZ	-	Government of the Republic of Zambia
GTZ	-	Germany Technical Aid to Zambia
HIP	-	Harmonization in Progress
HIPC	-	Highly Indebted Poor Countries
HIV	-	Human Immuno Virus
HMB	-	Hospital Management Board
HMIS	-	Health Management Information System
HQ	-	Headquarters
HR	-	Human Resources
HSC	-	Health Sector Committee
HSSP	-	Health Systems Support Programme
IMF	-	International Monetary Fund
JASZ	-	Joint Assistance Strategy for Zambia
JIFM	-	Joint Identification and Formulation Mission

M&E	-	Monitoring and Evaluation
MMD	-	Movement for Multi-Party Democracy
MMR	-	Maternal Mortality Ratio
MoFNP	-	Ministry of Finance and National Planning
MoH	-	Ministry of Health
MoU	-	Memorandum of Understanding
MTEF	-	Medium Term Expenditure Framework
MTR	-	Mid Term Review
NGOs	-	Non-Governmental Organisations
NHSP	-	National Health Strategic Plan
NMCC	-	National Malaria Control Centre
ODA	-	Overseas Development Assistance
OECD	-	Organisation of Economic Cooperation and Development
PEPFAR	-	President's Emergency Plan for AIDS Relief
PHC	-	Primary Health Care
PHO	-	Provincial Health Office
PRSP	-	Poverty Reduction Strategy Paper
RNE	-	Royal Netherlands Embassy
SBs	-	Statutory Boards
SIDA	-	Swedish International Development Agency
SAPs	-	Structural Adjustment Programmes
SWAp	-	Sector Wide Approach
TA	-	Technical Assistance
UNZA	-	University of Zambia
UNICEF	-	United Nations Children's Fund
UNFPA	-	United Nations Population Fund
USAID	-	United States Agency for International Development
WB	-	World Bank
WHO	-	World Health Organisation
ZANARA	-	Zambia National Response to HIV/AIDS

ABSTRACT

International recognition of the health problems being faced by developing countries have resulted in significant increases in external development assistance for health since the late 1980s. However, it has been established that this aid has not been effective due to poor coordination, harmonization and alignment. As part of the aid development architecture, donors and recipient countries have defined approaches, modalities and methods of working aimed at improving harmonization, alignment and management of aid for results. One such approach is the Sector Wide Approach (SWAp) which involves ensuring that "all significant funding for the sector supports a single sector policy and expenditure programme, under government leadership, adopting common approaches across the sector, and progressing towards relying on government procedures to disburse and account for all funds." (Foster et al, 2000a, p.6).

In Zambia, the health SWAp has been in existence since 1993. The adoption of the health SWAp was necessitated by a desire to optimize the use of domestic and externally mobilised financial and in-kind development assistance through the integration of all vertical programmes into a sectoral framework that would meet common national goals and objectives. This was after it was realised that the health system was inefficient in its provision of health services due to the existence of fragmented, multiple donor-assisted projects which the Ministry of Health could not effectively coordinate and manage.

This paper explores the contribution of the health SWAp to the provision of effective health care in Zambia since its inception in 1993. The study considered the SWAp as both an aid instrument and as a process and the evaluation is made by looking at both the individual elements of a SWAp and the SWAp mechanism as a whole. The study assesses the contribution of the SWAp to fostering working relationships, accountability for finances and progress, efficient allocation and use of resources, financial sustainability and promotion of geographical equity of access to health care resources.

The study was exploratory and a retrospective approach was used to track and associate changes *before* the introduction of the health SWAp and *after* the SWAp implementation period 1993 – 2005. In order to take account of certain contextual factors in the broad health reform continuum, a combination of qualitative and quantitative research techniques were used. This includes 21 in-depth key informant interviews, a Focus Group Discussion (FGD), non-participant observation at 4 different SWAp coordination meetings and a comprehensive document review. Study participants were senior members of the Health Sector Advisory Committee that were drawn from 6 provinces (including the capital city Lusaka). The actual selection of interviewees was done purposively based on the possession of requisite expertise, diversity and availability.

The Sector Policy and Management Review Toolkit (SPMRT) was one of the tools that was used to analyse the data from the FGD. Responses from all the qualitative instruments were condensed, inductively analysed and subsequently combined with quantitative data from the document review.

Some of the major findings of the research were:

- The Zambian health SWAp can be regarded as a full SWAp whose implementation has developed gradually and consultatively. However, varying degrees of successes and failures had been achieved when it came to the implementation of each element of the SWAp. Specifically, the implementation of the Medium Term Expenditure Framework (MTEF) budget and use of harmonised implementation mechanisms and procedures were found to be problematic. Apparently, three (3) financing mechanisms were in existence most of which were not aligned to the budget and National Health Strategic Plan (NHSP). The health SWAp was also found to be sector narrow in terms of stakeholder and consumer involvement as well as the range of programmes/activities that were being supported.

- CPs that were contributing to the basket were to a greater extent found to be more committed to the SWAp process than those that were not. Concerning ownership of the SWAp process by the government of the Republic of Zambia (GRZ), GRZ was not completely in control even though it provided leadership in the SWAp process.

- The adoption of the health SWAp has significantly contributed to improvements in financial management and accountability even though more had to be done in the area of procurement and accountability for performance. The implication was that the health system was not entirely performance oriented.

- The SWAp mechanism as a whole had not really made any notable contributions to improving administrative, technical and allocative efficiencies in that transaction costs were still high; there were a number of Cooperating Partners (CPs) using separate systems; the productivity of district hospitals was below par; and the distribution of GRZ resources among competing users was sub-optimal both in terms of budgeting and execution. It was also noted that GRZ funding was unpredictable as compared to CPs' funding and that there were fewer negative variations in budgeted amounts against the actual releases for basket funding in comparison to vertical programmes.

- There was inadequate support for drugs and human resources during the SWAp implementation period making it difficult to provide quality health care.

- Financial sustainability appeared not to have been attained as the growth of CPs funds (especially funding for vertical programmes) was more than GRZ funding and all

domestic sources during the SWAp implementation period. In addition, instabilities in the growth of funds from all sources were prevalent and that basket funds were growing at a slower rate than funding for vertical programmes despite the expansion of the basket. There were also inadequate funds to meet the requirements of the Basic Health Care Package while GRZ was unable to meet regional targets for funding the health sector as envisioned in the Abuja Declaration.

- It was noted that supporting a set of common activities as envisioned through the SWAp can increase sustainability in programme funding owing to the fact that GRZ did take up the task of funding the programmes in the health sector when the CPs reduced their support in times of partnership problems.

- The six-month buffer as a system meant to sustain operations in the health sector in the advent of short-term variations in funding couldn't take care of sudden but drastic changes in funding emanating from international exchange rate fluctuations.

- The SWAp had relatively promoted equity in the allocation of resources to districts through the use of a needs-based resource allocation formula but that formulae had to be developed for the other levels.

- There was a problem of physical access to health facilities despite the commitment of GRZ and its CPs to providing basic health services through the rehabilitation and construction of more health centres and health posts in rural areas. This was because the emphasis of the Zambian health SWAp is more on financing recurrent operational costs (especially the districts) than capital development.

- Lastly, it was noted that the SWAp had not adequately contributed to the correction of geographical (urban/rural) inequities in the targeting of resources towards the attainment of universal fully immunised children and institutional deliveries among women. Underlying/contextual factors that negated the attainment of geographical equity of access include the lack of human resources, lack of physical proximity to health facilities, and shortage of vaccines for child immunisation to mention but a few.

Realising that effective implementation of a health SWAp still remains a challenge to the Zambian government, a comprehensive list of policy recommendations have been suggested based on the study findings and conclusions. The idea is to allow the Ministry of Health (MoH) to decide on what to implement, through prioritisation in the interim to long term although suggested priorities are presented. Some of the key recommendations include the aligning of all financing sources to the NHSP and MTEF; strengthening stakeholder and GRZ ownership of the SWAp process; implementation of a viable performance management

system; streamlining of the number of SWAp coordination meetings; and improving the budgeting and execution processes.

Research gaps were also identified and suggestions for future work have been made. It is my sincere hope that this paper will be used as a tool for developing credible strategies for tackling challenges in the health sector.

CHAPTER ONE: GENERAL INTRODUCTION, OBJECTIVES AND ORGANISATION OF THE DOCUMENT

1.0 INTRODUCTION

This chapter brings the perspective of the study in focus by presenting the problem statement and its context, the rationale and significance of the study, and the general and specific objectives.

1.1 PROBLEM STATEMENT

According to the World Health Organisation (2000), every health system should provide *better health* to all its people, *respond to their expectations* and offer *financial protection* against the costs of ill-health. The World Health Organisation further suggests that the attainment of these goals depends on how well a health system executes four functions namely: *stewardship*, *creating resources*, *financing* (collecting, pooling and purchasing) and *provision of services* demanded by the population. In line with the minimum standards prescribed by WHO, several authors relate to some or all of the above functions when gauging the performance of a health system (IHSD, 2001b; Travis et al, 2004; Gottret and Schieber, 2006; Schieber et al 2006).

To date, not all the countries around the world have fully met all the goals outlined above, more especially the Least Developed Countries (LDCs). A myriad of reasons have been given for the poor health service delivery in LDCs and prominent among the reasons is the inadequate resources at the disposal of most LDCs that several scholars believe cannot bring about meaningful improvements in the health status of the people (Task Force on Health Systems Research, 2005; Gottret and Schieber, 2006; Schieber et al 2006). The understanding is that most LDCs have experienced several years of poor economic performance leading to decreased government revenues and a rising demand for health care. In addition to budgetary constraints, it has also been established that most health systems in LDCs are poorly organized and could thus not provide efficient and equitable health care (Travis et al, 2002; Task Force on Health Systems Research, 2005).

The international community has been in agreement for a long time on what needs to be done to meet the minimum standards for a health system in LDCs. The common perception is that major improvements in the health status of people in LDCs can only be attained through large-scale provision of funding to LDCs by international development agencies (Task Force on Health Systems Research, 2005; Gottret and Schieber, 2006; Schieber et al 2006). Secondly, reforming the organization of health services is a key solution to the inefficient and inequitable delivery of health care (Travis et al, 2002; Task Force on Health Systems Research, 2005; Hecht et al, 2006; Preker et al 2006). For these reasons, a

number of LDCs in the early 1990's commenced health sector reforms. Fundamentally, the line of argument was set on the 'New Public Management' thinking which advocates that governments should "move from a concern to do and towards a concern to ensure that things are done" (Travis et al, 2002). The 'New Public Management' approach meant "*separating the functions of purchasers and providers; creating internal or quasi markets within the public sector; creating executive agencies to manage the health sector; decentralizing health-service management to local health administrations or to local government; increasing the autonomy of hospitals; and making greater use of the private sector*" (Task Force on Health Systems Research, 2005; p.40).

Given limited budgets, efforts to mobilise sufficient financing in an equitable and affordable manner and to secure value for the money generated has been a common feature of the health reforms. In order to support the cause, many international agencies increased provision of resources to LDCs in support of a range of discrete projects and programmes. For example, Gottret and Schieber (2006, page xiv) note that, "international recognition of these global health inequities by the Group of Eight, the European Commission, and the United Nations, as well as global public health threats and support for countries to reach the MDGs, have resulted in significant increases in development assistance overall and development assistance for health in particular after almost a decade of decline in the 1990s.

Zambia is not an exception in the failure to meet WHO standards with regard to the health system. The economic stagnation experienced in the country since mid-1970 resulted in the decline of resources available for use in the public sector, including to the health sector. Consequently, health service delivery was adversely affected. This prompted the country to follow in the footsteps of LDCs and health reforms started in 1992. The intention of the health reforms was to realize a vision of "*providing Zambians with equity of access to cost effective, quality health care as close to the family as possible*" and to attain the overall national health goal of having "*a society in which Zambians create environments conducive to health, learn the art of being well and provide basic level health care for all*" (Ministry of Health, 1992 p.2).

An interesting feature of the implementation of the reforms in Zambia was the pace at which they were carried out. Mogedal et al cited by Lake and Musumali (1999) observed that Zambia's health reforms were the most radical and far-reaching in Africa, both in terms of the scope of change and the speed of implementation. This view was shared by other independent reviewers of the health reform process in Zambia who added that the build up of the reform process had centred on strong intellectual leadership, fortunate timing and generous donor support (Ministry of Health, 1997a). Thus, the reform process has since inception been owned by the government and the vision encompasses in-country experiences and insights from the academic world (ibid).

The Ministry of Health was determined to transform the health care delivery system from one that focused on sole government participation (funding and decision making) to one founded on strategic partnerships between the government and all the stakeholders in the health sector, including local and international development partners. The idea was to stimulate a national sense of ownership of the public health system and social responsibility. The health reforms also came with new means of financing the health sector through a mix of user-fees, pre-payment and social insurance schemes. The need to improve the efficiency with which resources are utilised also necessitated changes in resource allocation at various levels of the health care delivery system.

Several international development agencies hailed the health reform process and injected substantial financial and technical support into the health sector (Ministry of Health 1997a; Ministry of Health 2000a). Regrettably, it is argued that most of this aid did not lead to significant improvements in the health sector as it was not effectively managed to meet the national reform policies and objectives (Kalumba and Musowe; 1996). The problem was that most of the aid was channelled through a variety of vertical programmes and multiple donor-assisted projects which caused duplication of programmes and thus inefficiencies in the use of resources (Kalumba and Musowe; 1996; Lake and Musumali 1999). In addition, there was an increase in the workload of health workers due to the need to meet specific parallel reporting and financing requirements of donors, which was compounded by geographical inequalities as a result of targeted assistance (Buse & Walt, 1996).

In order to redress the trend, the MoH and its Co-operating Partners (CPs) made a shift from vertical programmes to a Sector Wide Approach (SWAp) so that all available financial resources could be effectively managed and utilised in an equitable and sustainable manner (Lake and Musumali, 1999). The SWAp emerged as part of the health reforms and one of its key features was pooled funding through a "Basket" arrangement. The term "basket funding" is an innovation of the MoH and it entails the pooling of financial resources from all sources (government and CPs) towards the implementation of programmes and activities contained in the national health sector strategic plan (Lake and Musumali, 1999). Thus, the operationalisation of "Basket funding" in 1993 was the first stage in the implementation of a health SWAp in Zambia. At the time that basket funding was initiated, common planning, budgeting and accounting procedures were not yet in place and the MoH and its CPs had to put in place various joint systems and mechanisms that would enable the introduction of a full SWAp (Lake and Musumali, 1999).

1.2 RATIONALE FOR THE STUDY

Since 1993, the MoH has made considerable progress in the implementation of the SWAp. While the mode of support has not entirely changed, the government has somewhat managed to harmonize and align support towards priority health programmes as enshrined in the National Health Strategic Plan using a single set of programming, implementation and reporting procedures. As a result, the share of external resources channeled through the public health sector accounting system has increased over the years. Firstly, the number of CPs contributing to the basket increased from five in 1993 to nine in 2003 and in turn, financial disbursements to the basket also increased from an annual average of **US$ 6.7 million** in 1995 to about **US$ 33.8 million** in 2003 (Daura and Mulikelela, 1998; Central Board of Health FAMS Unit). Secondly, between 2001 and 2005, an average of **US$ 100 million** was estimated to be flowing into the health sector from CPs each year out of which close to 45% of these resources were administered through the public health care accounting system (Ministry of Health, 2003). The government for its part also increased the share of its expenditure on the health sector from 5.7% in 1991 to 13.4% in 1994 but this figure later dropped to 11% between 1997 and 2000. Put differently, the overall total per capita expenditure on health rose from an estimated **US$ 8** in 1993/1994 to an average of **US$ 23** per year between 1995 and 2005 (Ministry of Health, 2002b; Ministry of Health 2003; Ministry of Health 2005b).

Several government policy memoranda and independent reviewers of the Zambian health reforms have explicitly stated that the adoption of the health SWAp has consistently encouraged stronger partnerships between the government and all the major stakeholders in the health sector (Ministry of Health, 1997a; Lake and Musumali, 1999; Kandimaa and Mattson, 2001; Frantz et al, 2004). Further, it is agreed by almost all the CPs operating in the health sector in Zambia that the health SWAp has the potential to make development assistance more effective and that the SWAp serves as an opportunity for Zambia to realise its health reforms (*Health Reforms at Work: Experiences with the Sector Wide Approach in Zambia, 2004. DVD Recording*). The key point is that the earlier vertical programmes had only impacted on specific targeted areas and not on the overall health system (ibid). As a consequence, more and more CPs have embraced the health SWAp as evidenced through the pooling of financial resources, use of the National Health Strategic Plan (NHSP) as the implementation framework, and joint monitoring and reporting procedures. It is envisaged that this move has led to efficient allocation of scarce resources.

However, even though it has been widely acclaimed that the paradigm shift from project/programme support to a Sector Wide Approach has transformed working arrangements and brought about improvements in the provision of health services, the mid

term review and the performance audit report of the National Health Strategic Plan (2001-2005) showed contrary results (Ministry of Health, 2003; Ministry of Health, 2004b). Apart from these reviews, it has been pointed out during several SWAp coordination meetings that the performance of the health care delivery system has generally been poor with the major concern being the declining service delivery and health status indicators. For example, the Maternal Morality Rate (MMR) increased from 649 deaths per 100,000 live births in 1996 to 729 deaths per 100,000 live births in 2002 while the percentage of supervised deliveries has remained stagnant at less than 50% since 1998 (Central Statistical Office, 1996; Central Statistical Office, 2002; Central Board of Health 2005). Furthermore, although the Infant Mortality Rate (IMR) decreased from 107 deaths per 1,000 live births in 1992 to 95 deaths per 1,000 live births in 2002, other child related morbidity indicators, such as Malaria, Respiratory infection: non-pneumonia, Diarrhoea: non-bloody have remained unacceptably high (Central Statistical Office, 1996; Central Statistical Office, 2002; Central Board of Health 2005). In addition, morbidity indicators amongst the general Zambian population are high relative to many other countries in Africa with the country's statistics bureau, the Central Statistical Office (2004), revealing that 13% of Zambians surveyed two weeks prior to the Living Conditions and Monitoring Survey (LCMS) III reported an episode of illness.

Owing to the above, critics have pointed out that the current health care delivery system has not been responsive to the needs of the people and they doubt the effectiveness of the SWAp as an aid instrument as well as a method of working (process). Thus, for a while now, the biggest question has been why after so much good-will and increased allocation of resources to the health sector by external Cooperating Partners (CPs), the Zambian health care delivery system has not performed according to expectation. Notwithstanding that the health SWAp cannot be equated to the broader health sector reform process and that it is not entirely accountable for development outcomes, a well-functioning SWAp mechanism (greater harmonization, alignment, transparency, improved policy development and joint monitoring of performance) should serve as a link to overall health sector development outcomes (Walford, 2003).

Thus, though it might be true that the implementation of the Zambian health SWAp has led to systems development, strengthened leadership and improved transparency and communication, some believe that it has made little or no contribution to improved service delivery. However, this impression could be due to the limited amount of sound research that has been done on the Zambian health SWAp and it suffices to say that most of the critics inadvertently base their arguments on unsubstantiated claims. Incidentally, when the SWAp implementation process commenced in Zambia 12 years ago, the world knew very little about health sector SWAps and no implementation guide and evaluation framework were present. At that time, Zambia was one of the few countries in the world that was implementing a health

SWAp and its implementation was and still is a *'learning-by-doing'* process (Lake and Musumali, 1999). Further, given an implementation span of 12 years, this is almost certainly the right time conduct an evaluation on the health SWAp as having done it earlier could have been inappropriate owing to inadequate lead-time to track changes.

In the absence of a comprehensive review, it has not been possible for the MoH to ascertain the extent to which the health SWAp has met its objectives let alone the root cause of some of the concerns that have been raised of late. For this reason, a study that is entirely devoted to ascertaining the contribution of the health SWAp on the delivery of health care in Zambia is of paramount importance and as such, this study intends to fill this information gap.

The motivation for undertaking this study hinges on two fronts. Firstly, it has been recognized the world over that research addressing health systems' constraints can substantially contribute to delivering effective interventions and that lack of health systems research will render the attainment of the Millennium Development Goals (MDGs) impossible (Task Force on Health Systems Research, 2005). Secondly, it is a well-known fact that implementation of a SWAp is not a clear-cut process and that its performance needs to be closely evaluated in order to find out if it is meeting its primary aims. A critical assessment of both the individual SWAp elements and the SWAp mechanism as a whole could, therefore, unveil certain factors that strongly influence the implementation of health SWAps. This can provide stakeholders with evidence-based information on how to refine the SWAp process itself leading to maximized impact of aid, to the benefit of the Zambian government and its people as well as the donors in terms of obtaining value for their investments.

1.3 OBJECTIVES OF THE STUDY

1.3.1 General Objective

To explore the contribution of the health SWAp to the provision of effective health services in Zambia

1.3.2 Specific Objectives

i. To provide an understanding of the content and scope of the SWAp in the health sector in Zambia

ii. To review the effectiveness of the SWAp coordination mechanisms in relation to improved ownership, transparency and accountability

iii. To explore the extent to which the SWAp has contributed to the efficient allocation and use of resources in Zambia

iv. To review the extent to which the SWAp has influenced the mode of support and financial sustainability in the health sector in Zambia

v. To review the contribution of the SWAp towards the improvement of geographical (urban/rural) equity of access to health care resources.

vi. To inform policy on how to further develop the SWAp in the health sector in Zambia

1.4 ORGANISATION OF THE THESIS

This paper explores the contribution of the health SWAp to the provision of effective health services in Zambia. Whilst this chapter presents the problem statement, rationale and objectives of the study, the other chapters are organized as follows:

Chapter two presents a country profile of the main political, economic and demographic issues as well as the key features related to the Zambian health system.

Chapter three provides a review of the available literature on health sector SWAps from around the world and Zambia including the conceptual framework that was used to explore the contribution of the Zambian health SWAp.

Chapter four outlines the study design, methodology, data collection tools and analytical techniques that were used during the study. An account of some of the main limitations that were encountered during the study is also provided.

Chapter five presents the findings of the research study as it relates to the objectives and conceptual framework that were laid down in order to explore the impact of the Zambian health SWAp. Detailed discussions are provided alongside the results vis-à-vis the implications on the provision of health services in Zambia.

Chapter six provides a summary of the main lessons learnt, policy recommendations and areas for future research.

CHAPTER TWO: COUNTRY AND HEALTH SYSTEM PROFILE

2.0 INTRODUCTION

This chapter provides a brief account of Zambia pertaining to political and macro-economic issues, demographic and social factors, and the health system profile. This includes the main features of the Zambian health system, major actors and service delivery. The overall aim of the chapter is to elicit a situational analysis of the Zambian economy and the factors that have been critical to the successful implementation of the core business of the MoH.

2.1 POLITICAL AND MACRO-ECONOMIC ISSUES

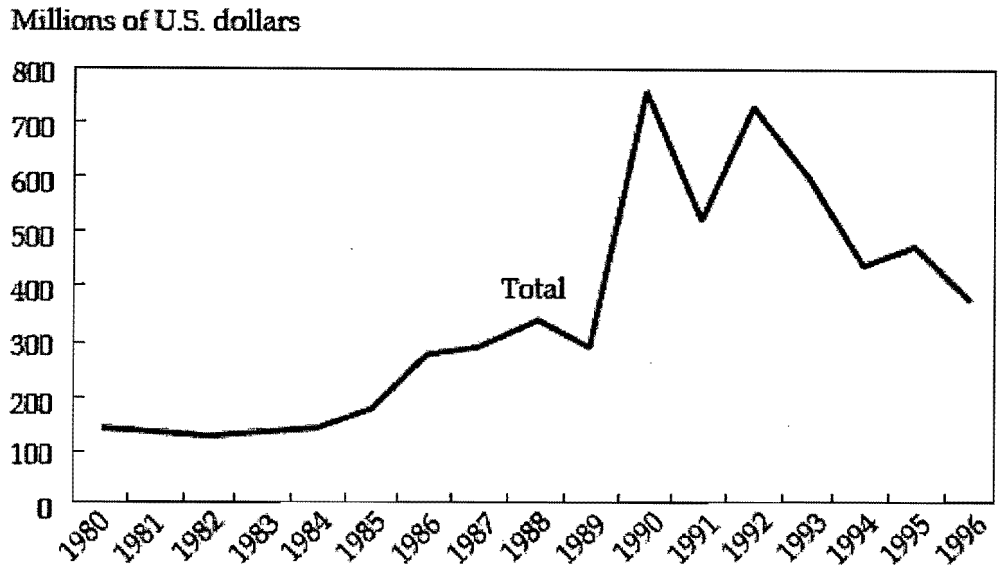
Zambia is a landlocked country located in the Southern-Central part of Africa and covers an area of about 752,614 square kilometres of land which is approximately 2.5% of the total area of Africa (Central Statistics Office, 2001). Zambia neighbours eight (8) countries namely Botswana, Zimbabwe, Mozambique, Malawi, Tanzania, Democratic Republic of Congo, Angola and Namibia. The country is one of the most urbanised countries in Africa and is administered through nine provinces representing 72 districts (Central Statistics Office, 2001).

Zambia's economy is predominantly dependant on copper production, which accounts for 95 percent of its export earnings and 45 percent of government revenue (ibid). Overdependence on the mining industry has over the years reverberated badly on the Zambian economy and as a result, the country's average annual economic growth rate has been one of the lowest in the Southern African Development Community (Government of Zambia, 2002). This can be attributed to a fall in the price of copper on the international market coupled with an increase in the price of oil that had been experienced in the mid 1970's. Between 1999 and 2003, it was estimated that on average, real economic output grew by 2.9 percent per annum while the GDP per capita was a meager US $359 (Government of Zambia, 2002; Seshamani et al, 2005).

The lack of real economic growth has transformed Zambia into a highly aid-dependant country and dependence on development assistance is said to have taken a major leap in the mid-1970s and later again in 1991 (Rakner et al, 2001). Aid is very important to Zambia and it has been shown that dependence on aid has increased both on a per capita basis as well as a percentage of the GDP (Rakner et al, 2001). In 1992 alone, Rakner et al (2001) estimate that the disbursements from external sources stood at 67% of export earnings and 77% of total public expenditure. Frantz et al (2004) estimated that in 2002, aid accounted for 18% of the GDP and was financing a large share of public expenditure. The high dependence on foreign assistance can also be evidenced from the large donor community of more than 150 international donor agencies that is currently working in Zambia (Rakner et al,

2001). An indication of the flow of external financial resources for the period 1980 to 1996 is shown in Figure 1.

Figure 1: Zambia: Total Externally Sourced Grants 1980–96



Source: (Rakner et al, 2001)

Unlike most countries in Sub-Saharan Africa, Zambia had during the 1970s and 1980s received substantial amounts of foreign aid in the form of structural adjustment loans over and above what was received in the form of grants (Rakner et al, 2001). As a result, by 2004, Zambia's external debt stock stood at US$7.1 billion and was one of the highest on a per capita basis in Sub-Saharan Africa (AfDB/OECD, 2004; International Monetary Fund, 2006). The total government indebtedness was estimated to be 61.2% of the GDP (Seshamani et al, 2005). Multilateral aid constituted the bulk of Zambia's external debt at 55%, bilateral aid at 39% and suppliers and other at 6% (International Monetary Fund, 2006).

International development partners have over the years attempted to reduce Zambia's debt but most of these efforts have centred on debt rescheduling and not actual cancellation (debt forgiveness) resulting into a debt overhang for years. For example, though Zambia qualified for debt relief through the Enhanced Highly Indebted Poor Country (HIPC) Initiative in 2001, the anticipated writing off of US$ 3.8 billion at completion point in 2003 didn't materialize in full. Since the HIPC completion point, the International Monetary Fund (IMF) has only been providing interim relief with the Paris Club creditors providing most of the debt relief. Thus, according to the 2006 national budget, Zambia's total external debt stock only reduced to US$ 4.5 billion in 2005 from US$ 7.1 billion in 2004 due to the interim debt write-offs by the IMF and some Paris Club members. It should also be mentioned that the pronouncement at the July 2005 Group of Eight (8) countries meeting that debt to the poorest eighteen (18) countries in Africa (Zambia inclusive) would be cancelled by 100% has not been adhered to.

However, as a result of the G8 pronouncement, the three (3) core multilateral institutions (IMF, International Development Association and the African Development Fund) were also prompted to extend 100% debt relief to Zambia and a group of other low-income countries under the Multilateral Debt Relief Initiative (MDRI). If the MDRI is effected, Zambia's total external debt will reduce from US$ 4.5 billion in 2005 to US$ 581 million (IMF, 2006).

From the foregoing, it is apparent that due to high indebtedness, resources meant for poverty reduction programmes have been used for debt servicing which on average accounts for 10% of the GDP (Government of Zambia, 2002). This leaves the government with only 3% of the GDP to allocate to the health sector for the provision of health services through the public health system (United Nations Development Programme, 2004). Marginal economic growth and the huge debt burden have made external funding a necessity and by 2001, 53% of the national budget was being funded from outside with the health and education sectors being heavily donor financed (Government of Zambia, 2002).

As a result of macroeconomic decline and high indebtedness, the national poverty level was estimated at 67% in 2002 with the highest incidence being in rural areas (Central Statistical Office, 2004). Specifically, while 74% of the rural residents were found to be poor, only 52% of the urban residents were poor (ibid). The picture above is further worsened by a high income inequality whereby the gini coefficient stood at 0.50 in 2002 (Government of Zambia, 2002).

2.2 DEMOGRAPHIC AND SOCIO-ECONOMIC FACTORS

Zambia's population was estimated at 10.8 million in the year 2002 out of which 65% of the people were living in rural areas and 35% in urban areas (Central Statistical Office, 2004). During the period 1990-2000, Zambia's population grew at an average annual rate of 2.4% (ibid). In addition, the country's average population density was estimated at 13 persons per square kilometre, though Lusaka province (hosting the capital city Lusaka) had the highest concentration of people at 64 persons per square kilometre (ibid).

Zambia has a relatively young population with the median age being 17 years in 2000 and 45% of the population below the age of 15. Unemployment is very high in Zambia and the overall dependency ratio was estimated at 96.2 in 2000. High unemployment coupled with a high dependency ratio present significant challenges to health care delivery (ibid).

2.2.1 Disease Burden

Being centrally located, Zambia is a transit point and distribution hub of the Southern African region and its locality has made the country a victim of diseases originating from its neighbours (Ministry of Health, 2004b). Additionally, the country is Africa's third largest

provider of humanitarian assistance to refugees (over 200,000 in total from DR Congo, Mozambique and Angola) and this has put more demands on the meager public resources available for health (Ministry of Health, 2001). The prevailing situation is one whereby there is a huge and escalating disease burden, inadequate drugs and medical supplies, dilapidated infrastructure and equipment and severely understaffed health facilities - a situation which has been accepted as a disaster (Ministry of Health, 2003). In order to overcome these challenges, the Zambian government is supposed to provide more resources to the health sector but is in all fairness financially handicapped to meet the feat.

Zambia's huge disease burden is also as a result of its location in a tropical region where climatic conditions are very favourable for malaria and diarrheoal diseases. A deeper understanding of the disease pattern also reveals that the disease burden varies by seasons with the most prevalent diseases being malaria, diarrheoa, acute respiratory infections, HIV/AIDS, peri-natal causes, tuberculosis, malnutrition, gastro-intestinal causes, maternal conditions and anemia. As of 2002, the life expectancy at birth had dropped from 54 years during the 1980's to 43 years (Central Statistical Office, 2002). Besides other contributing factors, the drop in the life expectancy is largely due to a high sero-prevalence of HIV/AIDS among adults aged 15 to 49 which was estimated at 16.8% in 2002 (ibid). This figure was initially at 20% in 1994 and had reduced by 4% by 2002 mainly due to the putting in place of several national HIV/AIDS prevention and control programmes (ibid).

2.2.2 Key Health Indicators

Zambia has some of the worst health indicators in Sub-Sahara Africa particularly the infant mortality rate, HIV/AIDS and TB prevalence rate. Table 1 below, shows some of the key health indicators in Zambia.

Table 1: Key Health Indicators: Zambia Vs. Sub-Saharan Africa (SSA)

	Zambia	**SSA****
Life expectancy at birth	43 years*	46.1 years
Infant Mortality Rate	95/1,000 live births*	108/1,000 live births
Child Mortality Rate	168/1,000 live births*	178/1,000 live births
Maternal Mortality Rate	729/100,000 live births*	-
Low Birth Weight	7.7 %*	-
Malaria related mortality	158/100,000 cases***	-
HIV/AIDS Prevalence (15-49yrs)	16%*	7.6%
TB Prevalence Rate	588/100,000**	495/100,000
Immunization Coverage	74%*	-
Births attended by skilled personnel	43 %**	42%
Population with access to an improved water source	64%**	57%
Population with access to improved sanitation	78%**	53%

*Sources: *ZDHS 2001/2002 **2004 Human Development Report ***2004 World Health Report*

2.3 HEALTH SYSTEM PROFILE

2.3.1 Background

Upon attainment of independence in 1964, health facilities were uneven and inequitably distributed in favour of urban populations and the emphasis was on curative care (Ministry of Health, 1997a). The government responded to this challenge by providing free medical care and expanding rural health facilities including district hospitals (ibid). At the time that free medical care was introduced, the population of Zambia was at 3 million people and the country's foreign exchange reserves were second only to South Africa in the African region (Musowe, 1992). The situation in 1993 was the exact opposite of the status in 1964 as the population grew to 8.3 million and the country was regarded as one of the poorest in Southern Africa (ibid).

Thus, the 1964 wind of change could not be sustained as the price of copper on the world market fell dramatically while the price of oil increased. By the end of the 1980's, the health care system disintegrated due to the fact that the government simply had no money to buy drugs as well as to maintain infrastructure, equipment and to retain health personnel. The state of affairs degenerated to a chronic shortage of drugs, run down infrastructure and equipment and migration of health personnel to foreign countries. This resulted in a fall in the quality of health care provided and a rise in morbidity and mortality indicators.

The defining feature of the health care delivery system at that time was centralized planning and decision making. Primary health care programmes were to a large extent neglected. As a consequence, planning for health and consequently service delivery were not linked to the needs of the communities. Poor accountability, transparency and inopportune partnerships with both local and external stakeholders were some of the other bottlenecks that rendered the health system ineffective. Kalumba and Musowe (1996; p. 159) describe the situation in a parable as follows:

"Zambia's health system has been likened to a Cadillac maintained for years by a relatively wealthy family. The family's economic situation has changed, and it can no longer afford to maintain this expensive vehicle without seeking assistance from cousins and relatives to help fuel, repair, and maintain the gas-guzzling vehicle. The alternative is to design and construct a more efficient vehicle that can meet the family's changing health care needs given its limited means."

As a result of the problems highlighted above, a new government that was ushered into power in 1991 engaged in a process of health sector reforms that commenced in June 1992.

2.3.2 Main features related to the Zambian Health System

The Zambian health reform process constitutes a desire to improve *"equity of access to cost-effective quality health care as close to the family as possible"* (Ministry of Health, 1992). The implementation of the health reforms are guided by principles of *Leadership, Accountability, Partnership and Sustainability* and this was designed to enrich open and wider public participation in the governance of the health system (ibid). The process towards attainment of the vision commenced with the decentralisation of authority and responsibility from the centre to districts. A movement towards a primary health care approach was initiated and this has made the district the basic unit of management and reference point for health service delivery in Zambia (Ministry of Health, 1997a). As a result, a total of 72 District Health Boards and 27 Hospital/Statutory Boards were constituted in order to ensure community participation in the delivery of health services.

The health reforms also initiated a purchaser-provider split through a re-definition of the role of the Ministry of Health whose mandate remained that of policy development, forward strategic planning, legislation, resource mobilization, external relations, and monitoring and evaluating (Ministry of Health, 2004a). On the other hand, the Central Board of Health (CBoH) was created as an autonomous agency responsible for the delivery of health services which included the commissioning of health services to district and hospital boards (ibid). The main changes that come with the health reforms are summarised in Table 2.

Table 2: Main Changes in the Zambian Health Care Delivery System

Resource Shifts	▪ From the centre to the operational levels ▪ Packaging of health services through the Basic Health Care Package (BHCP)
Shift in Planning & budgeting	▪ From central planning to locally developed district annual action plans ▪ From central budgeting to decentralised budgeting in the districts; including direct disbursement of funds to the districts
Paradigm Shifts	▪ From Project/Program to Sector-wide support ▪ Professional and Managerial Autonomy
Improving the Quality of Care	▪ Quality assurance and Accreditation System ▪ Capacity Building through the training of Staff ▪ Infrastructure Development and Rehabilitation
Improving Access to Health Care	▪ Building Health Posts in communities were people reside ▪ Strengthening the referral system through capacity building
Purchaser-Provider split	▪ Restructuring of the MoH and to limit its functions to policy formulation and legislation, resource mobilization and external relations ▪ Creation of the Central Board of Health (CBoH) and autonomous Health Management Boards to implement the health programme
Community Participation	▪ Establishment of popular participatory structures

Source (with modification by author): Ministry of Health, 1992

2.3.3 Major Actors in the Zambian Health System

The operation of the Zambian health care delivery system has since the commencement of the health reforms transformed from one fully centred on the MoH as a sole provider, to one based on strategic partnerships with all stakeholders in the health sector. A lot of partnerships have been formed and the major actors in the Zambian health system are:

- The Zambian Government (GRZ) through the MoH
- Line Ministries and Public Providers directly involved in health
- Co-operating Partners (Bilateral and Multi-lateral)
- Households
- Private Employers and Providers (firms, hospitals, clinics, hospices, pharmacies and other related facilities)
- Others (including for-profit and not-for-profit NGOs)

2.3.4 Health Care Financing

The major sources of health care financing in Zambia include government tax and non-tax revenues, grants and other forms of assistance from external co-operating partners, private companies, households and other sources which include NGOs and religious organisations. These sources include a total of eight (8) market-driven private insurance companies which are generally accessed by the rich as well as employees in the formal sector. Since the attainment of independence in 1964, GRZ has been the major single source of health financing but over the years, external co-operating partners and households have become very important sources of health care financing in Zambia. For example, the percentage of GRZ expenditure on the Total Health Expenditure (THE) was 41% in 1995 but this figure reduced to 38% in 2002. On the other hand, external co-operating partners contributions to THE increased from 12% in 1995 to 26% in 2002 (MoH, 2002b; Phiri and Tien, 2004). However, the contribution of households' to THE reduced from 32% in 1995 to 21% in 2002 but still remained an important source of health care financing.

Interestingly, all the other financing sources contribute more to THE than GRZ if summed up. Thus, GRZ decisions in the health sector must take into account other sources of financing. Regrettably, a comprehensive policy to inform stakeholders on health care financing is still non-existent.

2.3.5 Human Resource Staffing Levels

The human resources situation in Zambia has been described as a disaster (Ministry of Health, 2003). Most of the health facilities in the country are severely understaffed in terms of numbers, skills mix and geographical distribution. The current health sector human resource capacity is estimated to be operating at less than 50% of the recommended establishment

and most of the health centres in the rural areas are said to be manned by Classified Daily Employees (casual workers with no formal training in health).

2.4 SUMMARY

This chapter presented a succinct description of the Zambian economy, specifically an analysis of both the internal and external environment in which the Ministry has been operating since the attainment of independence in 1964. It was leant that the performance of the health sector has been unsatisfactory owing to inadequate resources, a huge disease burden due to the geographical location of Zambia, seasonality of diseases, emergence of new diseases, HIV/AIDS pandemic, and added workload due to a human resources crisis. Poor targeting of external aid and an unsustainable external debt were the other contributing factors.

It was clear that the Zambian government (GRZ) could not afford to adequately finance the operations of the health sector without external assistance. In a country where the poverty levels are estimated at 67% (Central Statistical Office, 2004) and whereby 18% of the GDP is from external funding (Frantz et al, 2004) the only way out is to use all the available resources in the health sector (both domestic and external) effectively. The implication is that GRZ should concentrate on the provision of cost-effective interventions while striking a balance between efficiency and equity.

CHAPTER THREE: LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

3.0 INTRODUCTION

This chapter presents a review of the available literature on health sector SWAps from around the world as well as Zambia. The review is structured in six areas that are relevant to the research topic, the problem, and its context. The six major areas that will be explored are: (1) the definition and concept of a SWAp, (2) the evolution and rationale for adopting health sector SWAps the world over, (3) principle benefits of a SWAp, (4) basic conditions for implementing SWAp, (5) principle risks and lessons learnt so far, and (6) the genesis, evolution and experiences with the health SWAp in Zambia. Concluding remarks are also presented on what the literature tells us about the methodologies and findings of previous studies on the impact of health SWAps around the globe and Zambia in particular.

Operational definitions of the key concepts used in the studies are later presented and the chapter ends by drawing out the conceptual framework that is used during the evaluation. .

3.1 DEFINITION AND CONCEPT OF A SWAp

There is no generally accepted definition of the concept of a SWAp in the literature. The World Health Organisation (WHO; 2000) defines a SWAp as a method of working between recipient governments and donors (herein after called Cooperating Partners - CPs), NGOs, consumers and all key stakeholders that are directly involved in the health sector. Although generally useful, the WHO definition is not as comprehensive and encompassing as that formulated by Foster et al (2000a, p.6) who suggested that the concept of SWAps involves ensuring that *"all significant funding for the sector supports a single sector policy and expenditure programme, under government leadership, adopting common approaches across the sector, and progressing towards relying on government procedures to disburse and account for all funds."*

Despite the existence of numerous definitions, there is consensus, however, on the key characteristics of a well-functioning SWAp. Walford (2003; p.3) summarises these characteristics as follows:

- Government stewardship in a sustained partnership with all stakeholders
- All significant funding agencies support a shared, sector wide policy and strategy
- A medium term expenditure framework or budget which supports this policy
- Commitment to move to greater reliance on Government financial management and accountability systems

- Shared processes and approaches for implementing and managing the sector strategy and work programme

The foregoing indicates that the concept of a SWAp involves identification of policies across the sector, agreement on resource allocation and a framework for ensuring transparency and accountability in the use of these resources. A good definition of a SWAp should generally take all these factors into consideration. The importance of taking on board all these characteristics is brought to the fore when an analysis of the rationale for having SWAps is undertaken.

3.2 EVOLUTION AND RATIONALE FOR ADOPTING HEALTH SECTOR SWAps

SWAps in general represent an approach to development aid that emerged in the mid 90s due to lack of progress in human development in several developing countries despite huge amounts of aid (Seco & Martínez, 2001). Literature suggests that the introduction of SWAps as a mechanism for aid delivery was driven by three main reasons.

Firstly, Seco and Martínez (2001) reveal that SWAps are an evolution of Sector Investment Programmes (SIPs) promoted by the World Bank since the late 1980s. They distinguish the SWAps from the SIPs by suggesting that SWAps were nationally-led sector development programmes which also have the added advantage of providing donors with an opportunity to engage in closer policy and institutional dialogue with recipient governments towards greater efficiency and effectiveness of aid. Given this added feature, SWAps have received a lot of support and interest from several bilateral and multilateral donors.

The second view is held by the World Health Organisation (1999) and the Institute for Health Sector Development (2001). These two institutions indicate that the evolution of health SWAps was instigated by the need to implement a second generation of reforms after the failure of Structural Adjustment Programmes. According to them, the idea of adopting health SWAps was to increase the effectiveness of development assistance and rational use of scarce resources by *"improving the budget process, capturing all sources of financing and all expenditures, and placing health sector plans within a rolling medium term budget where allocation decisions can be made in line with national priorities"* (WHO, 1999 p.3; IHSD, 2001 p.5).

The third and commonly held view over the evolution of health SWAps, however, stems from the need to replace traditional project approaches (vertical programmes) of the 1980's and early 1990's. The underlying view is that Health SWAps emerged as the preferred way of providing aid to developing countries after numerous concerns were raised about the ineffectiveness of vertical programmes in fostering sustainable improvements in health (Cassels, 1997; Jones, 1997; WHO 1999; Foster, 2000; Garner et al, 2000; Nokkala, 2003;

Walford, 2003; IHSD, 2004). The performance of vertical programmes was found to be ineffective and some of the problems that are commonly cited include:

- *Narrow in scope.* Though isolated projects may be successful at sub-sector level their performance at sector level are often limited. Further, vertical programmes concentrate scarce human and financial resources on a limited range of problems, and therefore hinder the development of comprehensive health systems (Jones, 1997; Brown, 2001).
- *Fragmentation and sustainability.* Multiple projects implemented by different donors tend to follow the priority of a donor and in the process they split the health sector along geographic, programme, and disease lines. Aid recipient governments often felt neglected and these projects are usually not sustained at the end of their tenure due to lack of commitment by aid-recipient countries to programmes that are seen to be entirely donor driven (Jones, 1997; Garner et al, 2000; Seco and Martínez, 2001).
- *Duplication.* Vertical programmes lead to a proliferation of poorly coordinated projects each with separate management systems (e.g. staffing, infrastructure, logistical and procurement systems). The common view is that donors would go as far as ignoring an already established integrated system and put in place their own parallel vertical programmes (Jones 1997; Garner et al, 2000; Brown 2001; Seco and Martínez, 2001).
- *Transaction Costs.* As a result of duplicated implementation and separate management arrangements, the cost of delivery increases since each donor negotiates and contracts separately. MoH personnel have to service a large volume of transactions on behalf of each donor through separate reports (Peters and Chao, 1998; Brown, 2001; Nokkala, 2003; IHSD, 2004).
- *Undermine government capacity.* Vertical programmes rarely make use of government structures and often sidetrack the implementation of public sector service delivery through the use of donor-led institutional arrangements that bypass government systems. This reduces overall government involvement and control (Brown, 2001; IHSD, 2004).
- *May lead to gaps in care.* Disjointed projects make it very difficult for patients to receive care from different uncoordinated service providers that are run by different donor projects. Therefore, it becomes difficult to refer patients from one provider to another (Brown, 2001).
- *Over-reliance on Technical Assistance.* Vertical programmes have a tendency of relying on external technical assistance and this has proved unhelpful to the development of local leadership, capacity and management systems (Jones, 1997).

As a result of the ineffectiveness of vertical programmes, SWAps were identified as an important approach to enhancing aid effectiveness. The shift to a broader approach to development assistance in the form of a SWAp was a desire to improve the returns from aid and more importantly, to address sector specific needs of the recipient country. The common thinking has been that health SWAps would address the shortcomings of vertical programmes if there is a commitment to change towards harmonised procedures built on strong partnerships and collaboration (IHSD, 2001). The understanding is that aid is more effective if more focus is put on developing and strengthening sector policies and institutional arrangements (WHO, 1999; IHSD, 2001).

Since the concept was developed, about 80 SWAps have been implemented across all sectors around the world out of which 85% are based in Sub Sahara Africa and being implemented in the Agriculture, Education and Health Sectors (Foster, 2000). Around the world, mapping of health sector SWAps reveal that the longest running health sector programme is the Social Action Programme in Pakistan, which was established in 1992 (Seco and Martínez, 2001). In Africa, the first country to have implemented a health sector SWAp is Zambia. To date, several countries around the world have implemented or are in the process of adopting health SWAps. This includes Bangladesh, Bolivia, Burkina Faso, Cambodia, Egypt, Ethiopia, Ghana, Kenya, Malawi, Mali, Mozambique, Nepal, Nicaragua, Pakistan, Papa New Guinea, Senegal, Sierra-Leone, Tajikistan, Tanzania, Uganda, Vietnam and Yemen (Seco and Martínez, 2001; Swiss Tropical Institute, 2006).

3.3 PRINCIPAL BENEFITS OF A SWAp

As mentioned earlier, the motivation for adopting SWAps was necessitated by the need for governments in developing countries to improve the effectiveness of development assistance and rational use of scarce resources (Walford, 1998; WHO, 1999; Foster et al, 2000b; Seco and Martínez, 2001). SWAps in health have merited attention because of their emphasis on partnerships between recipient governments and all key stakeholders operating in the health sector (Cassels, 1997; IHSD 2001; Seco and Martínez, 2001). SWAps are seen as an opportunity for recipient governments to regain control over their fragmented health sectors and the test over time is strengthened governments' ability to oversee the entire health sector, development of viable policies and plans, and sound management of scarce resources (Seco and Martínez, 2001; Izard and Dugue, 2003). The assumed core advantages of a sector-wide approach are as therefore:

- Greater efficiency and equity
- Decreasing transaction costs
- Sustainability and continuity in policy development and implementation

3.3.1 Technical and Allocative Efficiency

It has been established that vertical programmes lead to duplication of efforts and that they generally fragment aid along priorities that are set by CPs. On the other hand, SWAps endeavour to harmonize and align all available development assistance to a single sector policy and the desire is to have all the CPs supporting the entire health sector in a comprehensive and coordinated manner (Cassels, 1997; Peters and Chao, 1998; Hutton and Tanner, 2004). Provided that the full resource envelope is captured, allocation of resources to different levels of the health care delivery system can be objectively determined and resources channeled to areas of the greatest need to meet priority national programmes (Cassels, 1997; Peters and Chao, 1998; Seco and Martínez, 2001). In this sense, it is argued that SWAps promote allocative efficiency by unifying financing from all sources and improving transparency in resource use.

The justification for assuming that sector-wide targeting of aid is critical to achieving better health outcomes is presented by the World Bank (cited by Nokkala 2003) which postulates that SWAps, in general, are based on supply-side economics. The assumption is that paying attention to supply-side processes like common management arrangements can maximise participation leading to the identification and implementation of good policies, appropriate plans and priority health sector interventions. All parties in the health sector become aware of the common priorities for the health sector and they strive to ensure that adequate attention and resources are provided to these interventions (Brown, 2001). Apparently, research findings by Dollar and Collier (cited by the IHSD, 2001) show that aid was more effective in addressing poverty if sound policies were put in place. Since SWAps allow all players to have a say and to influence policies in the health sector, donors are comfortable with such an arrangement.

3.3.2 Reduced Transaction Costs (Administrative efficiency)

Vertical programmes are unpopular because they outstrip the administrative capacity of aid receiving countries by redirecting staff and/or overuse of staff due to multiple reporting requirements. In contrast, it is argued that SWAps reduce transaction costs due to their focus on partnerships and harmonization. Emphasis on the use of common planning, implementation and reporting arrangements makes it easier to coordinate all the programmes in the health sector universally and to rationally utilise staff and time (Cassels, 1997; Brown, 2001; Seco and Martínez, 2001).

3.3.3 Improved Equity in Access for Equal Need

There is a widely held view that SWAps are actually pro-poor by design and that they augment efforts to decentralize the provision of health services through a primary health care approach (Seco and Martínez, 2001; Hutton, 2003). Brown (2001) supports this view but

adds that this depends so much on delivering a *cost-effective* essential health care package on which SWAps should be based. In this case, allocating scarce resources to priority programmes and areas of greatest need through an essential health care package can create more opportunities for vulnerable members of society and translates to improved geographical equity in access (urban/rural) to health care resources.. Promotion of pro-poor strategies can empower the people in greatest need of health which in turn leads to a greater utilization of health services and increased social and financial protection (Seco and Martínez, 2001; Nokkala, 2003).

3.3.4 Sustainability of Policy Development and Implementation

In a SWAp, the government and CPs jointly plan and agree to implement programmes drawn from a broad set of priority national policies and strategies using existing national systems (Cassels, 1997). It is believed that implementation of programmes in this manner can strengthen national systems and in the process encourage ownership and sustainability. In fact, IHSD (2004) points out that sustainability, capacity building and systems development are an integral part of engaging in SWAps. In this regard, the use of national systems and common management arrangements potentially offers protection and security for priority programmes (WHO, 1999; Brown, 2001; Schleimann et al, 2003).

3.4 BASIC CONDITIONS FOR IMPLEMENTING A SWAp

As pointed out in section 3.3 above, the literature suggests that a SWAp can offer an interesting alternative to project support. However, implementation of a SWAp is not in itself a panacea for the health sector as lessons from various literature ably show. It should be understood that SWAps are not entirely appropriate for all countries and sectors (Foster et al, 2000a; Nokkala, 2003). This is because a SWAp is a dynamic process which is implemented differently across different countries (IHSD, 2004). Furthermore, certain conditions have to be met before adopting the SWAp. Foster et al (2000a) propose that an assessment of the environment most appropriate for a SWAp and aid delivery options should be considered on the basis of the country's level of capacity and its policy environment.

Ideally, SWAps are said to be essentially appropriate in highly aid dependant countries where the government is unable to sufficiently finance its recurrent and capital budgets; where the donor contribution is large enough for co-ordination to be a problem; and where governments are willing to let donors influence sector policy and link it to resources (Foster et al, 2000a; IHSD, 2001).

3.5 PRINCIPAL RISKS AND LESSONS LEARNT

A number of authors have questioned the effectiveness of SWAps since they took prominence in the mid '90s. Garner et al (2000) and DFID (2001b) have stated that there is

no evidence that SWAps actually work and have stressed that CPs have only embraced health SWAps based on the assumed promise of the concept. Garner et al (2000) and Brown (2001) go as far as stating that the major weakness of SWAps is that there is no framework for evaluating them and can thus, have the potential to make things worse if implemented haphazardly.

Even with their inefficiencies, the argument is that vertical programmes did have some positive features which should be retained under the SWAp. For example, vertical programmes are said to be very effective in delivering high quality treatment and prevention programmes and made a huge contribution to disease control (Brown, 2001). Further, a number of vertical programmes were being implemented in hard-to-reach areas that the general public health system was not servicing, promoting equity of access and improved health status of the poor. As such, donors involved in the SWAp would want to see that all the key advantages of vertical programmes such as the poverty focus, technical quality, regular comprehensive monitoring, predictable funding and assured funding of priority health interventions are maintained (Brown, 2001). In this regard, it is argued that SWAps should be incremental processes that should complement the positive features of vertical programmes (Brown, 2001; Seco & Martínez, 2001).

Studies on whether SWAps have built upon vertical programmes or improved health care systems have yielded conflicting results. The following sub-sections shed more light on the potential risks of SWAps and lessons learnt so far.

3.5.1 Technical and Allocative Inefficiencies

One of the key arguments for a SWAp has been that it leads to efficiency in resource use by defining funding modalities and setting standards of how aid and overall resources in the health sector should be utilised. Nonetheless, Sundewall and Sahlin-Andersson (2005) argue to the contrary and point out that most countries implementing SWAps were still operating in project modes. This has been reinforced by the recent emergence of global health initiatives like the Global Fund to fight HIV/AIDS, TB and Malaria (GFATM), World Bank HIV/AIDS fund, President's Emergency Plan for AIDS Relief (PEPFAR), WHO 3 X 5 Initiative, Stop TB, GAVI and Roll Back Malaria which are redefining modalities of aid delivery by providing earmarked funding (Schleimann et al, 2003; Frantz et al, 2004; Hutton and Tanner, 2004; Waddington, 2004). The argument is that global health initiatives are threatening the existence of SWAps because they often fragment aid and duplicate efforts; have their own reporting requirements and are unsupportive of the overall national sectoral plans and common management structures. In reality, inefficiencies still exist in SWAp implementing countries due to lack of coherence particularly when it comes to reporting and funding arrangements (Brown, 2001). IHSD (2004) takes note of this problem and suggests that SWAp implementing countries

should be committed to move towards joint reporting and pooled funding arrangements when all systems are considered adequate.

3.5.2 Reduced Government Funding

Contrary to the view that SWAps improve the financing base for delivery of priority interventions, Izard and Dugue (2003) are of the opinion that SWAps actually lead to reductions in or static government spending on health. The reasoning is that SWAps have not led to increased funding to the health sector because the recipient countries reduce their spending to the sector with increased injections by CPs. As a result, total health expenditure remains the same and in some cases even reduces, even if more CPs come on board. This phenomenon is widely referred to as aid fungibility and several authors including Walford (1998); Annan (1999); Kandimaa et al (2001); Izard and Dugue (2003) and Waddington (2004) provide numerous examples on the matter. To mitigate this problem, IHSD (2001) calls for broad policy dialogue and addressing issues of financial sustainability in the context of the level and effectiveness of public expenditure as a whole.

3.5.3 High Transaction Costs (Administrative Inefficiency)

The other observation against the health SWAp is that it does not really lead to reduced transaction costs (IHSD, 2001; Seco and Martínez, 2001; Foster et al, 2000b). IHSD (2001) and Foster et al (2000b) note that independent CPs' review missions are less frequent in a SWAp but much larger and more intensive. This is because new and additional demands for information are placed on the recipient governments with the same CPs still maintaining projects and requesting governments to provide parallel information as well (Seco and Martínez, 2001; Foster et al, 2000b).

Johanson (cited by IHSD, 2001), provides evidence on the above and indicate that supervision costs by the World Bank were 50% higher for SWAp implementing countries than for projects. Foster et al (2000b) explore this phenomenon and they explain that in cases where relationships lack strong trust, the CPs are forced to demand more information. Even so, IHSD (2001) sums up the argument by claiming that even if transactions costs have not reduced, the net benefit of a SWAp is that there is a rich government/CPs partnership that is supporting the effectiveness of government systems rather than parallel project systems.

In Zambia, Frantz et al (2004) make a strong observation on the above issue and they indicate that the scale of the GFATM and PEPFAR initiatives alone have the potential to significantly destabilise the public health system given the high levels of funding, and transaction costs from the management of these funds outside the SWAp. Banerji (2004), however, takes a neutral view and suggests that earmarked funds through global initiatives could be instrumental to the harmonization of approaches by providing a single multi-sectoral

governance structure with the full involvement of the private sector. The key was on how the earmarked allocations are designed to supplement the pool of other resources.

3.5.4 Reduced pro-poor focus

It has been argued that SWAps have failed to retain and build on the positive elements of vertical programmes due to the reorganization of technical responsibilities and focus on the macro level (Brown, 2001). This ultimately makes it difficult to address the needs of poor people at grass-root level and negates the view that SWAps improve equity of access (Brown, 2001; Seco and Martínez, 2001). In fact, Seco and Martínez (2001) observed that there is limited evidence to support the claim that SWAps actually match priorities with the available monies and they disagree with the perception that resources have been shifted towards primary and preventive health care programmes. Walford (1998), Garner et al (2000), Hill (2002b) and the Royal Tropical Institute (2003) support this view and allude to the fact that SWAps had the potential to overlook priority programmes such as reproductive health, child health, HIV/AIDS, Malaria and TB.

The above concern can be looked at from two angles. Firstly, how the SWAp should maintain the same level of importance and funding for key public health interventions as provided by vertical programmes. Secondly, how to sustain the provision of high quality services as achieved by vertical programmes. In Zambia, this issue was particularly expressed in a study by Bosman (1998) who observed that the TB control programme had been negatively affected as a result of the introduction of health sector reforms which placed emphasis on sector funding. Seco and Martínez (2001) tie up the argument by showing that in practice, donors and governments essentially take a midway approach by targeting certain resources to the poor through vertical programmes while simultaneously addressing macro-policy issues through the SWAp.

3.5.5 Limited Government Leadership and Stakeholder Participation

Though it is envisaged that recipient governments should provide leadership and that there must be wider national stakeholder participation in the SWAp process, the extent to which SWAps has led to this is limited (Benson-von der Ohe et al, 2000 cited by Land and Hauck, 2003; IHSD, 2001; Royal Tropical Institute, 2003; Jeffreys et al, 2003; Hutton and Tanner, 2004). The argument is that the inter-sectoral aspect has not worked well because SWAps have only been developed at sub-sectoral level and have mainly focused on districts/primary level (Cassels, 1997). The underlying problem has been how to define the sector and reviewers note that the focus of a SWAp should be comprehensive enough to encompass all public and private institutions financed, managed or regulated by the MoH (Cassels, 1997; Peters and Chao, 1998).

Peters and Chao (1998), however, recognize that the above description might marginalize other health programmes outside the realm of the MoH and call for the formulation of viable linkages with all the institutions supporting major health programmes/activities. Cassels (1997) adds that the development of common management systems for monitoring performance and tracking funds for the entire sector could be one way of integrating all programmes and activities in the sector. IHSD (2001, p. 12) adds that *"as SWAps mature, the planning and budgeting functions of a MoH have incrementally captured greater and greater fragments of existing action, and new investment".*

3.5.6 SWAp and Decentralisation

Several researchers have studied the interrelationship between SWAps and decentralisation and the extent to which the two complement/conflict with each other. One line of argument is that SWAps are a challenge to the decentralisation process because they tend to privilege centralized decision-making processes and control mechanisms (Seco and Martínez, 2001; Gould cited by Land and Hauck, 2003). The main concern is that SWAps re-centralise power by strengthening lines of accountability between the recipient government and donors while undermining lines of accountability between the recipient government and local stakeholders (Seco and Martínez, 2001; Gould cited by Land and Hauck, 2003; Royal Tropical Institute, 2003; Walford, 2003). This point of view is supported by Jeppsson (2002) who reported that the health SWAp negotiation process in Uganda was mainly between the donors and the Ministry and that the districts were only involved to a very limited degree.

However, Land and Hauck (2003) point out that the relationship between SWAps and decentralisation is complex and that it unfolds in varying ways. They explored the phenomenon in Tanzania and Uganda where they found that SWAps were being used as tools for supporting decentralisation processes (devolution) in a number of institutional contexts. A study by Kasumba and Land (2003) that was conducted in Uganda also found that SWAps were in fact not in conflict with decentralisation and that the two were actually strengthening the local government system through the continued usage of national structures. The reasoning is that a SWAp benefits from the decentralised structures (various boards and committees, meetings etc.) at the lower levels in its quest to improve the allocation of resources, and accountability for finances and performance. On the other hand, emphasis on the use and strengthening of local systems/structures as envisioned in the SWAp, sustains the decentralisation process.

Hutton (2003) takes a middle stance and concludes that expectations of SWAp and decentralisation relied on how health services were managed whether vertical, integrated, or somewhere in between. He points out that if centrally-managed vertical health programmes

for all priority activities existed, decentralisation and the SWAp might not work in harmony. On the other hand, if there is a process of health service integration and health care delivery is by basic health services, SWAp and decentralisation worked well. Ultimately, Hutton postulates that the overall goals of decentralisation and SWAps were compatible to an extent whereby the SWAp is greatly enhanced by functioning decentralised government systems while decentralisation itself is made more effective by the funds and capacity-building associated with the SWAp.

3.5.7 Partnership Problems: Reform, Attribution and Policy Influence

The other argument against the SWAp stems from the difficulties in implementing and managing the process itself (Garner et al, 2000; Brown, 2001; Seco and Martínez, 2001). For a SWAp to be effective, Peters and Chao (1998) suggest that both the government and CPs have to ***realign their working arrangements*** through structural and policy changes. However, while recipient governments may subscribe to change, the degree of change on the CPs' side is often constrained by administrative, philosophical and political reasons (Cassels and Janovsky, 1998; Peters and Chao 1998; IHSD, 2001; Hill, 2002b). Therefore, as the SWAp is being implemented, more pressure is put on the government to reform its planning, budgeting, financing and procurement arrangements while no demands are put on the CPs (IHSD, 2001; Izard and Dugue; 2003).

One of the reasons that push CPs to pressurize recipient governments is the loss of attribution in a SWAp. ***Attribution*** of results to individual CPs sources is lost in a SWAp, and as such, recipient governments have to reform their systems to ensure transparent, accurate and timely financial and progress reporting (Cassels and Janovsky, 1998). This has in the process led to unreasonable demands on recipient governments and in the event of weak government capacity to implement and manage the change, negotiations sometimes fall apart as governments can no longer succumb to pressure and the CPs lose confidence in the system (IHSD, 2001; Izard and Dugue, 2003).

Related to the above is the argument that SWAps ***open up national polices*** by allowing CPs and other stakeholders in the health sector a greater say in policy formulation (Cassels and Janovsky, 1998; Seco and Martínez, 2001). The implication is that the policies that were eventually formulated are not ideally government owned but policies devised by CPs missions.

3.5.8 No Blue-print for a SWAp

Lastly, notwithstanding that there are common elements among countries implementing SWAps, it has been established that all the SWAp implementing countries define and apply

SWAps according to their own contexts (IHSD, 2004; Sundewall and Sahlin-Andersson, 2005). This makes it difficult to make substantive international comparisons.

3.6 ZAMBIAN HEALTH SECTOR SWAp

3.6.1 Background

Prior to the commencement of the health reforms and subsequent introduction of a health SWAp, Zambia's health sector suffered from excessive centralization, policy gaps, lack of well defined systems, weak partnerships and irregular availability of funds at almost all levels of health care (Danish Ministry of Foreign Affairs, 1994). A system for harmonizing external assistance was not in place and the health sector was characterized by fragmented, multiple donor-assisted projects to an extent whereby the Ministry was unable to effectively coordinate and optimally utilize the aid (Kalumba and Musowe, 1996). The desire for improved management of aid was inevitable and the Ministry had to find a way of pooling resources as well as to integrate all the vertical programmes into a sectoral framework that would meet common national goals and objectives.

The emergence of a SWAp in the health sector in Zambia came in early 1993, when DANIDA perceived a need to improve the institutional capacity and provision of basic health services at district level (Lake and Musumali, 1999). As a result, the first "common basket funding" was made operational in mid 1993 when DANIDA, SIDA, ODA, EU and UNICEF started pooling and channeling financial resources directly to districts to support recurrent budgets at district and community levels (Danish Ministry of Foreign Affairs, 1994; Phiri, 2003). The Zambian government also bought into the idea and made the first disbursement to the district basket in January 1994.

However, the evolution to a formal health SWAp did not come without difficulties. Most of the CPs were at that time still skeptical about the likely impact of the SWAp, especially those that were running projects that were making positive achievements (Musowe, 1992). In order to be sure of a positive return on their investments when they joined the SWAp, CPs wanted the government to address the following concerns (Musowe, 1992; p.1):

- The degree to which resource allocation matched agreed policies;
- The impact of health care financing policies on the poor;
- The financial sustainability of the sector;
- The effectiveness of the systems for procurement of goods and services;
- The reliability of accounting and auditing systems;
- Meeting CPs' individualized reporting requirements; and
- Agreeing on high level indicators for monitoring performance which the CPs tended to value differently.

The Zambian government endeavoured to work on the donor concerns and adopted the SWAp ideals with the development of the NHSP 1995–1998 ("From Vision to Reality") which provided the basis for launching the Health Sector Support Policy which is now called the SWAp. Between 1997 and 1999, the MoH and CPs sought to formally embrace the SWAp and a process of developing a Memorandum of Understanding commenced (Phiri, 2003). After extensive consultations, the Memorandum of Understanding (MoU) was eventually signed on 24th November 1999 by thirteen (13) CPs that included DANIDA, DFID, IRELAND AID, SIDA, EU, ROYAL NETERLANDS GOVERNMENT, USAID, UNICEF, WORLD BANK, UNFPA, UNDP, WFP and WHO. The signing of the MoU outlined the institutional framework and guidelines for cooperation between the Ministry and all CPs in the SWAp whereby common systems for planning, reporting, disbursements, accounting, auditing and procurement were to be used. The move also expressed a commitment by the Zambian government and all the CPs to formally adopt the SWAp for support towards the national health strategic plan (Ministry of Health, 1999).

The MoU made it clear that the government and its CPs preferred the channeling of all monetary support to the basket. Common "basketing" of donor funds entails the provision of un-tied financial support to health sector action plans as contained in the National Health Strategic Plan (NHSP). The aim of "basketing" was to bring all internal and external funding "on-budget" and to use the pooled financial resources within the framework of the NHSP in a simple, efficient and effective manner (Kalumba and Musowe, 1997; Ministry of Health, 1999; Ministry of Health, 2003). As a way of mapping out commitments towards the provision of monies to the basket, an indicator on the percentage of donors who were providing funds through the basket was used.

Recognizing that change is not spontaneous, the MoU also provided for the continuation of vertical approaches for endemic and contagious diseases such as HIV/AIDS, TB and Malaria (Ministry of Health, 1999). It was also explicitly stated that 60% of the total CPs funds were to be spent at district level while the government was to spend 50% of its resources at district level (Ministry of Health, 1999). Emphasis on providing more resources to the district through the basket made the government's commitment to decentralisation a reality (Frantz et al, 2004).

The Zambian Health SWAp has over the years also placed emphasis on the provision of interventions enshrined in the Basic Health Care Package which entails providing the most cost-effective interventions against Zambia's burden of disease at all levels of the health care delivery system (Phiri, 2003). The idea of the Basic Health Care Package is to ensure universal access to basic health services in a climate of limited resources. Thus, in the

Zambian Health SWAp, priority setting and resource allocation have to be in line with requisites of the Basic Health Care Package.

As a result of adopting the SWAp, Zambia has been commended for providing a model for partnering international CPs with governments in support of a locally designed reform process (Oxford Policy Management cited by Lake and Musumali, 1999). The scope of the SWAp has grown rapidly and a number of CPs are now heavily involved in the SWAp with varying modes of support towards the NHSP. Table 3 below presents a chronology of the Zambian Health SWAp.

Table 3: Road Map to Zambia's Health SWAp

1991	• First National Consensus Conference held in Livingstone, Zambia to review the performance of the health sector, policies and strategies
1992	• National Health Policies and Strategies
1993	• Health Reform Implementation Team (HRIT) created
	• Direct "Basket" funding to districts by 5 CPs namely: DANIDA, SIDA, ODA (DFID), EU and UNICEF
1993/4	• District and Hospital Health Management Boards • Neighbourhood Health Committees
	• User fees
1994	• Development of the NHSP 1995 - 1998
	• Financial and Accounting Management System (FAMS) and Health Management Information System (HIMS) created
1995	• National Health Services Act passed
1996	• Defined National Basic Health Care Package
	• Central Board of Health
	• Independent Review of the Health Reforms
1997	• Development of the NHSP 1998 – 2000
1999	• Signing of the MoU between MoH and CPs
	• Partial Hospital HMIS
2000	• Joint Identification and Formulation Mission
	• Development of the NHSP 2001 - 2005
2003	• Basket funding expanded to secondary and tertiary hospitals, CBoH and MoH headquarters
	• Medium Term Expenditure Framework introduced by government
	• Draft Code of Conduct (CoC) as an instrument for conflict resolution in the SWAp
November 2003	• Mid Term Review of the NHSP 2001 - 2005
March 2004	• Re-organisation of SWAp Coordination Mechanisms
June 2004	• Institutional and Organisational Appraisal of the health sector
October 2004	• Basket funding expanded to Statutory Boards, Training Institutions in form of capital expenditure and human resource development.
2005	• Policy decision to repeal the National Health Services Act of 1995 to pave way for the dissolution of the Central Board of Health
	• Development of the NHSP 2006 - 2010
December 2005	• Revision of the MoU between MoH and CPs
2006	• Shift to Direct Budget Support - DFID and EU • CBoH formally dissolved

Data Sources: MoH, 1992; MoH, 1997a; MoH, 2000a; MoH, 2003; MoH, 2004a; MoH, 2004b

3.6.2 Emerging Issues

Research on the Sector-Wide Approaches on the delivery of health services in Zambia is insufficient and mainly takes the form of administrative reports and assessment memoranda. This is despite the wide range of activities that are being supported by the SWAp and the high level of support provided by CPs and the Zambian government. The paradox is that though Zambia was the first country in Africa to have implemented a health sector SWAp, thereby involving a great deal of "learning by doing", the country has no tangible evidence on the impact of SWAps. This is a matter of great concern for CPs involved in the SWAp given that they lost the ability to independently attribute their investments to achievements when they discontinued with their individually-funded programmes and joined the SWAp (Hutton and Tanner, 2004).

To date, of all the studies that were accessed, only one study adequately addressed the contribution of the health SWAp in Zambia. The study in question was conducted by Lake and Musumali (1999) who looked at the role of aid management in sustaining the Zambian health reform vision. They outlined the different coordination mechanisms that the Zambian government and its CPs had put in place and assessed them in terms of selected criteria of effectiveness. The main finding was that the health SWAp was not meeting the reform objectives due to ineffectual personalities and human interaction; the nature of reform processes; and the impact of broader contexts. However, this study was conducted when the SWAp was in its infancy and it focused more on management structures and relational issues and did not evaluate the SWAp mechanism as a whole. In addition, the study was done when the health SWAp was still very new and was merely an informal process that needed a lot of refining. At that time, the MoU between the governments and its CPs had not yet even been signed.

The other study on the Zambian health SWAp was conducted by Kandimaa and Mattsson (2001) who analysed SIDA's Sector Programme Support to the Zambian health sector (2002-2005). This study was basically an assessment memorandum whose aim was to describe and analyse the context of the Zambian health reforms, long-term sustainability of the reforms and areas for continuing SIDA support for the period 2002-2005. This assessment did not critically look at the contribution of the SWAp and only addressed broader health sector reform issues that were holding back the attainment of the national health reform vision.

In addition to the above two studies, Frantz et al (2004) recently made an assessment of the effectiveness of USAID's Sector Programme Assistance (SPA) in the context of the achievements of the district basket in Zambia by looking at the evolution of the health SWAp, support for decentralisation, financial sustainability and outcome/impact indicators. They observed that the milestones that USAID uses to guide SPA disbursements to the district

basket had generally been met and that the SWAp had improved predictability of resource transfers; initiated the development of sound financial management and monitoring systems; increased accountability for resource use; and developed a system for health services delivery that is more responsive to the preferences of the Zambian citizens (Frantz et al, 2004: p.1-2). Further, it was revealed that participation in the SWAp though the SPA had given USAID a great deal of influence over how the total resource envelope was being allocated in Zambia.

Though useful, the study by Frantz et al (2004) placed a lot of emphasis on the effectiveness of the SPA in the context of the achievements of the district basket and no attempt was made to assess the contribution of the overall Zambian health SWAp. A SWAp should be looked at as both an aid instrument and as a process, and the study by Frantz et al did not examine all the components of the Zambian health SWAp as it only centred on the achievements of the district health basket. The methodology and data analysis techniques that were employed were also not stated.

In an attempt to evaluate how the SWAp is translated as it is adopted in different country settings and how the translations elicit changes in practice, Sundewall and Sahlin-Andersson (2005) conducted a three-layered comparative study of Uganda, Zambia and Bangladesh. The findings were that SWAp was a clear label with unclear content and that it had limited potential to transform standards of aid management since the administrative structures in recipient countries were formed in project modes. The conclusion was that change could only be brought about if the definition and content of the SWAps were worked on.

The study by Sundewall and Sahlin-Andersson (2005), however, did not evaluate the contribution of the health SWAp to improved service delivery. This is because the study treats the SWAp as a reform model and compares its translation at policy level in each country with SWAp models found in the literature and daily practice. It should be borne in mind that though the SWAp can be regarded as a reform model, its implementation is country specific and should be regarded as a dynamic process stimulated through a method of working. This process is entirely country specific and the dynamism of the process actually models the way aid should be managed. Sundewall and Sahlin-Andersson appear to be analysing the SWAp model itself by looking at its place in the architecture of aid management and whether it suffices to be qualified as a developmental model. In this case, I take a different approach. The intention of my study is to evaluate the *content* and *scope* of the health SWAp in Zambia and its contribution to effective provision of health services.

3.7 SUMMARY OF KEY ISSUES IN HEALTH SWAps

In summary, I hold the view that the available literature on the impact of health SWAps in enhancing service delivery is based on cogent reasoning and not on hard evidence. The information that has been gathered thus far merely points to how the SWAp concept can be brought forward, its merits and potential risks. Most scholars agree that nearly all countries implementing SWAps (Zambia inclusive) have developed coherent sector plans and have set up joint systems to monitor performance and that partnerships and the role of governments in policy implementation have been strengthened. In Zambia, such systems include the Financial Administrative Management Systems (FAMS) and Health Management Information System (HMIS) which have greatly assisted in enhancing transparency and accountability in financial and progress reporting. However, it is postulated that the expected benefit of using joint systems has not materialized as transaction costs have actually increased in most SWAp implementing countries.

The few studies that have been conducted in Zambia generally point to the fact that the Zambian health SWAp has led to an increase in funding and that recipient districts are able to predict when funds would be released. Nonetheless, the view that SWAps lead to increased funding to the health sector was questioned by several authors because no one knows what may have happened if there was no SWAp. What is clear is that there has been corresponding reductions in government funding with increased CPs support. In addition, there was no evidence that health SWAps lead to financial sustainability and whether in fact they enhanced equity of access by the poor. Even so, the agreement was that though SWAps may not be inherently pro-poor they were also not anti-poor. The degree to which they would benefit the poor depends largely on the actual policies contained and implemented by each country.

There is a strong indication that global health initiatives are undermining the existence of SWAps due to their separate planning, budgeting and reporting arrangements. This creates inefficiencies in resource use and the arrangement is unsustainable. It was also established that most health SWAps have not adequately involved NGOs and the private sector. This is despite the commonly held view that SWAps complement the decentralisation process.

Lastly, most scholars did not provide empirical evidence on how health SWAps could lead to better health outcomes. The reason is simple. Almost all the studies that have been conducted on health SWAps are mainly accounts of the status of country implementation of health SWAps rather than outcome/impact assessments. As Garner et al (2000; p.3) note, *"most of these evaluations often lack substance because they are done by experts employed by CPs and that the reports themselves rarely have a methods section, are usually unpublished and restricted in circulation".* The common argument has been that health

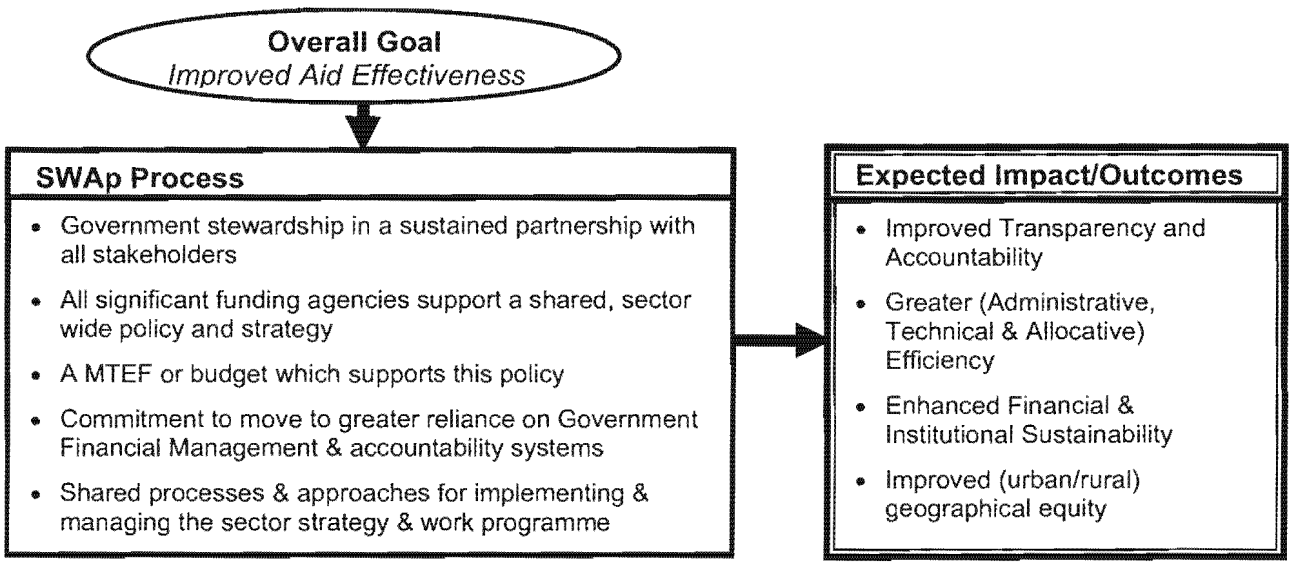
SWAps are new and that the SWAp is a long term approach designed to strengthen the reforms of a health system. Though it is appreciated that sustained reform takes time, Hutton and Tanner (2004) observe that development partners have to point to concrete achievements if they are to continue supporting SWAps. Without the existence of in-depth studies on health SWAps, it is difficult to critically evaluate the methodologies as most of the available data mainly constitutes ideological standpoints.

Given the above background, this study seeks to examine in more detail, the contribution of the health SWAp to the provision of effective health services in Zambia. Assessment of impact will be done by looking at the effectiveness of resource management, efficiency in the use of financial resources (pooled and other targeted funding), geographical equity in access to health care resources, financial sustainability, and relational and collaborative processes.

3.8 CONCEPTUAL FRAMEWORK

The conceptual framework as presented in Figure 2 will be used to structure the results and discussion. The evaluation draws from the literature review and is conceived from two perspectives. Firstly, in relation to the SWAp process, a critical analysis of each of the five (5) elements of a SWAp as they are applied in practice in Zambia will be done. Secondly, regarding the effectiveness of the SWAp process as a whole, the expected impact and outcomes of a SWAp process such as greater efficiency, improved transparency and accountability, enhanced financial and institutional sustainability and improved geographical equity of access to health care resources will be reviewed. Given the problem of establishing causality, attention will be paid to analysing the extent to which the SWAp might have or might not have contributed to a particular impact/outcome.

Figure 2: Overall Goal and Expected Impact/Outcomes



Drawing from the literature review, the overall goal of implementing a SWAp is to *improve the effectiveness of aid.* The understanding is that implementing the five elements of a SWAp as shown in Figure 2 would *strengthen mechanisms for aid management* and that the mechanism as a whole would *strengthen the health system leading to better health outcomes.* In examining the impact of the health SWAp as a whole the underlying expectations are as follows:

i. The SWAp mechanism as a whole improves transparency and accountability through increased dialogue and communication, development and use of robust systems, and synergy with the decentralisation process.

ii. The SWAp mechanism as a whole promotes administrative, technical and allocative efficiency by reducing the duplication of services; enhancing harmonization of procedures; encouraging the production of maximum services at lowest cost; and optimality in the distribution of resources among competing uses.

iii. The SWAp mechanism as a whole enhances financial sustainability by directing all forms of support to the NHSP.

iv. The SWAp mechanism as a whole corrects geographical inequities (urban/rural) in the targeting of assistance by increasing the use of objective tools in resource allocation and efforts to reach the rural areas leading to lower levels of mortality and morbidity.

The conceptual framework is used alongside a set of key performance indicators that were developed to assess the performance of the health sector. The comparator is the pre-SWAp implementation period and changes from baseline right throughout the SWAp implementation period (1993-2005) will be tracked by using the set of performance indicators and qualitative judgement.

It should be borne in mind that analysing the impact of a SWAp is complex and Walt et al (1999a, p.207) argue that, *"concern with the effectiveness of aid coordination arrangements must give way to a broader analysis of the processes, outputs and outcomes governing the use of both external and domestic resources, focusing on institutional characteristics, the distribution and nature of influence among the actors, and the interests which they pursue through the aid regime".*

CHAPTER FOUR: METHODOLOGY AND STUDY LIMITATIONS

4.0 INTRODUCTION

This chapter provides the study design, methodology, data collection tools and analytical techniques that were used during the study. An account of some of the main limitations that where encountered during the study are also provided.

4.1 METHODS USED BY SIMILAR STUDIES

It is difficult to outline a clear cut methodology that has been employed by the few studies that have been conducted on health SWAps in Zambia and around the world. This is because most of the literature on the subject matter is not backed by hard evidence generated from empirical research. Most of these studies have simply mapped the countries implementing health SWAp and progress towards the realization of the five core elements of a SWAp as outlined in section 3.1. Compounding the problem has been the diversity of the countries implementing health SWAp, the unavailability of common indicators, and lack of a generally agreed upon framework for evaluating SWAps.

The study made use of a framework for evaluating health SWAps that was developed from the literature review as presented in Figure 2. It should be understood that collection of data that entirely bears on the SWAp was not possible as the SWAp is a process which influences the broader health system. Thus, when assessing the impact of a SWAp, one has to make use of overall health sector performance as opposed to narrowly defined and easily measurable project type outcomes and outputs. As a result, influences as to what the SWAp has achieved was made through the use of qualitative judgement that was solicited from qualitative research techniques and analysis of quantitatively information routinely collected by health facilities through the Health Management Information System (HMIS) and the Financial Administrative Management System (FAMS).

4.2 STUDY DESIGN

The study was exploratory and a retrospective approach was used to track and associate changes *before* the introduction of the health SWAp and *after* the period 1993 - 2005 that SWAp had been in implementation in the health sector in Zambia. However, the study did not exclusively employ '*before* and *after*' comparisons as qualitative judgement was applied in order to take account of the impact of certain contextual factors, in the broader health reform continuum, that might have occurred during the implementation of the health SWAp. Hence, a combination of qualitative and quantitative research techniques were applied in order to gain a broad understanding of the issues and to make it easier to formulate causal links. A blend of key informant interviews, focus group discussion, non-participant observations of SWAp coordination processes and a comprehensive document review were used.

4.3 STUDY SITES AND PARTICIPANTS

The study was conducted in Zambia and interviewees were drawn from the Health Sector Advisory Committee and one private hospital. The essence of using the Health Sector Advisory Committee is that it has sector-wide participation from MoH, bilateral and multilateral CPs, global health initiates, statutory boards/bodies, the University of Zambia, NGOs, civil society and the private sector.

The selection of interviewees was done purposively based on the possession of requisite expertise, diversity and availability. Expertise in this case means the possession of a considerable amount of experience as it relates to working in the Zambian health sector. Diversity on the other hand implies ensuring that there was adequate representation from a cross-section of stakeholders operating in the health sector. This was due to the fact that a thorough understanding of the subject matter was being solicited from a wide selection of individuals with an established know-how/institutional memory of the Zambian health system. Interviews with current and relatively new entrants to the health sector as well as those from the academia also provided valuable information on the perceived contribution of the Zambian health SWAp. The study specifically benefited from comments from a visiting lecturer from the Karolinska Institutet in Sweden who was a co-author of a three-layered comparative study of the SWAp process in Uganda, Zambia and Bangladesh that was conducted in 2005.

Eight (8) categories of participants were formulated and representation was sought from each group. The categories include: bilateral CPs (contributing to the basket); bilateral CPs (running vertical programmes); multilateral CPs; serving senior MoH/CBoH officials (national and provincial levels); retired architects of the Zambian health reforms; lecturers from the University of Zambia/Karolinska Institutet; NGOs; and the private sector. The interviewees that were eventually selected from the Health Sector Advisory Committee were based in Lusaka (the capital city of Zambia) and five (5) other provincial centres namely: Northwestern, Southern, Northern, Copperbelt and Eastern.

4.4 DATA COLLECTION TECHNIQUES

The data collection process occurred over a period of 3 months from November 2005 to February 2006. Qualitative data was collected through face-to-face interviews, focus group discussion and non-participant observations. During the interviews, an interview schedule containing a series of questions from seven (7) thematic areas that were drawn from the study objectives was used. The author was the sole interviewer and even though the interview schedule was standard, questions were administered according to the appropriate expertise and category of the interviewee.

As part of the quantitative component, a comprehensive document review was carried out and a data extraction form was used to extract information from various national and international documents.

4.4.1 Key Informant Interviews

Specifically, a total of twenty-one (21) in-depth interviews were conducted with senior members of the Health Sector Advisory Committee based at central and provincial centres and one private hospital. All in all, there were 4 interviews with senior MoH officials based at MoH headquarters; 2 interviews with Provincial Health Directors based in Western and Northwestern provinces; 1 interview with a retired bilateral health advisor/architect of the Zambian health reforms; 4 interviews with bilateral CPs (contributing to the basket); 1 interview with a bilateral CP (running vertical programmes); 3 interviews with multilateral CPs; 2 interviews with senior lecturers from the University of Zambia; 1 interview with a visiting lecturer from the Karolinska Institutet in Sweden; 2 interviews with specialists from the Health Systems Support Programme (NGO); and 1 interview with a Consulting Surgeon from Luanshya Mine Hospital (private sector). All the responses were recorded electronically and on average, each interview lasted for an hour.

An interview schedule (Appendix V) was used during the interviews and the questions were designed to assess the origin and brief understanding of the Zambian health SWAp, governance and management; membership and participation; resource allocation; financial sustainability; financial management; monitoring and evaluation; perceived quality, utilization and access; constraints, failures and areas of improvement. The main aim was to investigate the extent to which implementation of the individual elements of a SWAp were impacting on the health system and in particular, stakeholders' views on the contribution of the health SWAp to health service delivery.

4.4.2 Focus Group Discussion (FGD)

One focus group discussion was conducted with five (5) provincial financial specialists from five (5) provincial health offices namely: North-western, Southern, Northern, Copperbelt and Eastern provinces. The group was engaged for two and half hours and the Sector Policy and Management Review Toolkit (SPMRT) was administered to the group so as to establish clearly defined attributes of the SWAp concepts, working arrangements and policy issues. The SPMRT was developed by the Royal Tropical Institute (KIT) from the Netherlands and was piloted in Zambia during the mid term review of the NHSP 2001-2005 in the year 2003. The SPMRT is a dynamic toolkit that is adapted in different contexts (country situational analysis, programme or sector assessment etc.) and its usefulness lies in its ability to facilitate discussion and stimulation of critical appraisal and assessment through dialogue with all key stakeholders. The SPMRT was deliberately used because it is very handy in

analysing qualitative and quantitative issues relevant and related to programme implementation on a multi-sectoral level.

The process of applying the SPMRT began by introducing each individual to each of the five elements of a SWAp which were used as thematic areas. The group was asked to assess various aspects of each thematic area taking into consideration successes and failures towards the implementation of each thematic area. A quick scan of the Zambian health SWAp was generated and the fact sheets that were later produced elicited a rich discussion on the organisation, management and impact of the Zambian health SWAp.

Four possible options were given in order to come up with the best fit and the respondents were required to score from zero as the least possible score to three (3) as the maximum possible score. The description of the current status were indicated as 0=Not Achieved; 1=Partially Achieved; 2=Substantially Achieved; 3=Fully Achieved. In addition, the respondents were asked to provide a description of the best fit after scoring and consensus on the attainment of each component was then mapped out through a plenary session. The FGD upon debate and assessments then reached consensus based on their experience in respective provinces and other evidence in existence. An extract of the quick scan (with closed ended responses) that was used is provided in Table 4 below.

Table 4: Quick Scan on the five core elements of a SWAp

COMPONENT	STAGES OF DEVELOPMENT AND CHARACTERISTICS			
1. ***Financing modalities of external support***	*All support to the sector is provided through individual projects, each having its own systems*	*Some CPs use the basket funding arrangement as well as other financing mechanisms*	*Several CPs pool resources through the basket funding arrangement*	*Despite the existence of several financing mechanisms, all funding to the sector is aligned to the NHSP*
Best Fit				
Description of Best Fit				
2. ***Government Stewardship***	*Policy Formulation is predominantly donor driven*	*Importance of national ownership is recognized but most donors still overrule government's decision in order to satisfy their specific mandates*	*There is greater movement towards national ownership though more has to be done*	*There is national ownership and all partners share responsibility*
Best Fit				
Description of Best Fit				

Using the above framework, it was possible to assess the stage at which the implementation of the health SWAp had reached vis-à-vis the realization of each of the five core elements of a SWAp and whether there was continued movement towards a full/extensive SWAp.

4.4.3 Non-Participant Observations

Working arrangements and relational issues were looked at in more detail through non-participant observations of the 2005 MoH/CPs Annual Consultative Meeting; January and February 2006 Policy Consultative Meetings; four (4) Implementation Review Steering Committee Meetings and four (4) Monitoring and Evaluation Steering Committee Meetings at national level. Specifically, attention was placed on establishing the level of stakeholder participation and ownership by looking at the quality of the consultative process, extent of commitment to the SWAp, shared responsibilities, honouring of pledges and other overarching issues on the management of the SWAp.

A full description of the above meetings is provided in Appendix 1.

4.4.4 Document Review

A number of documents were reviewed covering the periods before the implementation of the Zambian Health SWAp (pre-1993) and after the adoption of the health SWAp (1993-2005). The documents that were looked at included: government policy documents and legislation; research articles; CPs assessment memoranda; Joint Investment Plan (JIP); Income and Expenditure Reports; Economic reports; Health Management Information Systems (HMIS) reports; Financial and Administrative Management System (FAMS) reports; Health Sector Committee basket reports; MTEF budgets; Demographic and Health Survey reports; Local Conditions Monitoring Survey reports; National Health Accounts; Joint Health Appraisal Mission (JHAM); national and international Journals; minutes/videos of previous SWAp coordination meetings; and unpublished papers.

Apart from the documents reviews, a lot of data was also extracted from MoH and CBoH data bases such as the FAMS, HMIS, human resources and planning departments.

4.5 DATA ANALYSIS

The Sector Policy and Management Review Toolkit (SPMRT) as provided in sub-section 4.4.2 was used to analysis the data from the FGD. The responses from the FGD were then combined with the responses from the Key Informant Interviews (KII) through an inductive approach. The purpose of using an inductive approach is because it is a convenient and efficient way of analysing qualitative data as it allows one to condense extensive and varied raw data into brief statements. The inductive approach also makes it possible to establish clear links between the research objectives and the findings derived from the raw data.

By using the inductive approach, responses from the Key Informant Interviews were electronically transcribed and then coded according to thematic themes from the study objectives such as *level of stakeholder participation, ownership, transparency* and *accountability, financial sustainability, efficiency* and *geographical equity of access to health care resources*. The process of coding involved the identification of raw text segments with similar meaning units which were categorized according to the study objectives. Raw text segments were added to each category until all the relevant texts as it relates to the study objectives were exhausted. An analysis of the categorized data then followed and the inclination was towards answering the research objectives. The findings from the qualitative research (FGD, KII and non-participant observation) were subsequently combined with quantitative data and triangulated with available literature.

In the process of data analysis, several softwares were used and this included Microsoft Word, Microsoft Excel and SPSS 13.0. The data was presented in tables and graphs (line graphs, bar charts, pie charts and spider web) to show the trends in performance indicators.

It is important to note that qualitative data provided insights on variables relating to human behaviour such as relational and governance issues and made it possible to identify potential causal linkages and perceived impact of implementing a SWAp. Conversely, quantitative data that was extracted from the documents was used to quantify the size, distribution and associated changes in performance indicators.

Analysis of the study findings also greatly benefited from the author's 3 years experience as the SWAp Coordinator in the SWAp coordination secretariat, MoH – Zambia.

4.6 OPERATIONAL DEFINITIONS AND MEASUREMENT OF VARIABLES

The variables that will be measured to gauge the contribution the health SWAp to the provision of health services in Zambia are as follows:

i. Governance and Management (including level of participation and ownership)
ii. Efficiency (Administrative, Technical and Allocative)
iii. Financial Sustainability
iv. Geographical Equity (urban/rural)

During the course of the study the above variables/terms were used according to the definitions given below.

4.6.1 Governance and Management

Governance is broadly defined as *"processes by which organisations are directed, controlled, and held to account and is underpinned by the principles of openness, integrity and*

accountability" (ECSAFA, 2004). Governance as defined above constitutes probably all the elements that need to be looked at in a SWAp in order to assess the effectiveness of the management structures and processes for decision making, accountability, control and behaviour of stakeholders. The Zambian health sector SWAp places emphasis on the formulation and implementation of robust joint administrative systems that include planning and progress reporting, accounting and audit, procurement and technical assistance. An examination of the effectiveness of these systems vis-à-vis ownership, transparency and accountability was done.

Ownership on the other hand refers to the extent to which there is commitment to the SWAp process by all stakeholders (Walford, 2003). Ownership goes further than mere stakeholder participation and thus, a distinction was made between participating in a SWAp and actually owning the process. Ideally, the behaviour of stakeholders, shared responsibilities and quality of the consultative process reflect the extent to which stakeholders own the SWAp process. Key informants with sound knowledge of the Zambian health sector were relied upon to offer candid expressions on what they felt about stakeholder ownership of the SWAp including government's leadership role when it comes to making key decisions in the SWAp consultative process. The other angle was to look at the growth in financing for the health sector. Stakeholders who consistently provided increased sums of money to the health sector were regarded to own the process more.

4.6.2 Administrative Efficiency

Administrative efficiency is attained if the resources used in the management of the health system are attained at the lowest possible cost. In a SWAp, administrative efficiency is improved if the common management arrangements (joint monitoring, reporting and funding procedures) lead to lower transaction costs than separate systems for individual projects (Brown, 2001; Walford, 2003). In evaluating if transaction costs have increased or not, the number of meetings, comprehensiveness/time spent in the meetings and the number of CPs using separate systems were looked at. Key informants were relied upon to gauge what the situation was before the SWAp in order to obtain an adequate comparator.

4.6.3 Technical Efficiency

Hutton (2000; p.7) indicates that "a technically efficient health system is one that produces given outputs with the least inputs, or alternatively produces the most outputs from given inputs". The essence of measuring technical efficiency was to ascertain if resources were being used in an appropriate manner such that as many outputs as possible are produced from a combination of inputs, while maintaining adequate quality of care.

Support system indicators like the hospital bed occupancy rate (measuring productivity of district hospitals) and the health centre staff daily contact rate (measuring level of productivity of staff at health centres) were looked at. The benchmarks for the hospital bed occupancy rate and the health centre staff daily contact rate were drawn from the MoH national requirements of 80% occupancy and 15 contacts per staff per day, respectively.

The other measure of technical efficiency that was looked at was expenditure on drugs as a percentage of the total health budget (GRZ & CPs). Drugs were singularly picked upon because they are one of the major cost drivers in Zambia and the availability of essential drugs is considered to be a proxy indicator for the quality of health care provided. The comparator was the annual estimated requirement for drugs and medical supplies for the Zambian public health system that the MoH has estimated at US$ 21,000,000.00 (MoH, 2001; MoH, 2003). This calculation, however, does not include the annual cost of vaccines.

4.6.4 Allocative Efficiency

This refers to how resources are allocated between different levels of the health care delivery system to produce health services that have the greatest impact on health (McPake and Kutzin, 1997). The extent to which the health SWAp has promoted allocative efficiency was assessed by looking at the amount of resources allocated at district level, level 2 hospitals, level 3 (tertiary) hospitals, training institutions and headquarters. This is against the milestones stipulated in the NHSP (2001-2005) that a minimum of 60% of the total resources coming from CPs and government are supposed to be channeled towards the provision of district health services; 20% to major referral (2^{nd} and 3^{rd} level) hospitals; 10% to MoH headquarters and the remaining 10% to Statutory boards/Training Institutions. In addition, an effort was made to look at the performance of the budget and timing of disbursements. The other task was to find out if resources were being allocated to the most cost-effective priority interventions as contained in the Basic Health Care Package (BHCP).

4.6.5 Financial Sustainability

The operational definition of financial sustainability is adopted from McPake and Kutzin (1997) who define financial sustainability as *"the extent to which national health expenditures are funded from domestic resources and the long-term stability of a mix of funding sources".* The aim was to look at the growth rate of health sector financing from all sources over time before and after the advent of the health SWAp, particularly external funding which is supposed to grow at a slower rate than domestic funds. Even so, the growth rate of pooled funding, which is regarded to be a more sustainable financing mechanism as compared to funding for vertical programme, was looked at.

4.6.6 Equity in Access

The effectiveness of any health system is measured by looking at the degree to which it leads to improved health status of the people that it serves (Hutton, 2000). In measuring the changes and inequalities in the health status of people, equity issues normally come into play more so equity of access.

Equity of access for equal need as a distributive principle requires leveling the costs of health care consumption across patients with identical needs (Mooney, 1983). Bearing in mind that people in rural areas have more needs than their urban counterparts and that health related costs in rural areas are generally higher than urban areas, the equity consideration would be to allocate more resources to rural areas. Mooney (1983, p.180 & 182) suggests that equity of access is a supply-side criterion and explicitly points out that the term 'equity of access' means 'equality of opportunities'.

An attempt was made to find out if the SWAp mechanism as a whole has corrected geographical inequities (urban/rural) through the use of needs-based resource allocation formulae in the Zambian health care delivery system. An assessment of *geographical equity of access* was made by making *urban/rural comparisons* before and after the SWAp and the indicators that were looked at include the Population to Staff ratios depicting changes in staffing of core human resources between 1991(before the SWAp) and 2005 (after the SWAp). The WHO recommended workloads for doctors, clinical officers, nurses and midwives were also used as a benchmark.

Other indicators that were looked at include the growth rate in the supply/distribution of health facilities; the Fully Immunised Coverage against the national target of 80% coverage; and the number of institutionally supervised deliveries after the SWAp against the baseline of 50.7% in 1992.

Table 5 below provides a full description of what data was gathered and how the variables were measured as related to the study objectives and conceptual framework.

Table 5: Objectives and Measurement of Variables

Objective	Inputs/outcomes/ Intermediate Objectives	Variables & Indicators to be measured	Source of Information
1.To provide an understanding of the content and scope of the SWAp in the health sector in Zambia	*Operationalising the SWAp* ▪ Conceptualization and key features of the Zambian health SWAp ▪ Structural changes and extent to which the Zambian health SWAp embraces the five common characteristics of a SWAp as highlighted in Section 3.1	• Policies, Strategies & Key Objectives	National Health Strategic Plans, Joint Review Reports, Policy Documents
		• Collaborative processes & management systems in place	National Health Strategic Plans, Joint Review Reports, FGD, Key Informant Interviews, Non-Participant Observations at SWAp Meetings
2.To review the effectiveness of the SWAp coordination mechanisms in relation to improved ownership, transparency and accountability	*Better value from aid transaction costs, while strengthening national systems and capacity* *All stakeholders influence policy and resource allocation* *Government leads donor coordination, policy development and planning*	• Number of stakeholders involved in the SWAp & level of participation • Quality of the consultative process • Ownership - extent of commitment to the SWAp, shared responsibilities, honouring of pledges etc.	FGD, Key Informant Interviews, Non-Participant Observations at SWAp Meetings, Past Minutes/Videos, Basket Reports, Joint Review Reports
		• Coordination mechanisms • Financial management and accountability procedures and systems in place	Joint Review Reports, Basket Reports, Key Informant Interviews, FGD, SWAp Minutes/Videos
3.To explore the extent to which the SWAp has contributed to the efficient allocation and use of resources in Zambia	*Greater efficiency in the use of resources*	***Administrative Efficiency*** • No. of meetings • Time spent in meetings • % of CPs using joint systems of reporting & financing	Key Informant Interviews, FGD, MoU, Joint Review Reports
		Technical Efficiency • Hospital Bed Occupancy Rate • Health Centre Client Contacts • % spent on Drugs Vs Operational Costs	Key Informant Interviews, FGD, HMIS data base, Annual Health Statistical Bulletins, Annual MoH Reports, National Health Policies & Strategies
	Objectivity in Resource Allocation ▪ GRZ and CPs have kept to the agreed expenditure patterns for the resources it controls ▪ Public Expenditure patterns against key influencing objectives	***Allocative Efficiency*** • % spent at different levels of health care • Budget performance (%age of actual releases from pledged amounts) • Use of the BHCP	NHA, MTEF, Health Reforms Selected Papers, Draft National Health Care Financing Policy, Annual MoH Reports, Joint Review Reports, Key Informant Interviews, FGD

4.To review the extent to which the SWAp has influenced the mode of support and financial sustainability in the health sector in Zambia	*Commitment to move towards a pooled, flexible, predictable and sustainable funding mechanism* ▪ External resources coordinated with national plans ▪ Existence of systems to mitigate sudden withdrawal of funding	• Growth rate of health sector expenditure (all sources) • Share of external assistance to Total Health Expenditure/pooled funding • Exist Strategy & Short term sustainability	NHA, Joint Review Reports, FAMS data base, Health Reforms Selected Papers, MoH Planning data base, Key Informant Interviews, FGD
5.To review the contribution of the SWAp towards the improvement of geographical (urban/rural) equity of access to health care resources	*'Better' policy and resource allocation for the whole sector* ▪ The sector policy and strategy places emphasis on poverty reduction and efforts to reach the rural areas ▪ Are more health services being provided to benefit the vulnerable (Children and Women)?	***Geographical Equity in Access*** • Use of needs-based resource allocation formulae • Population-Staff ratios • Distribution of health facilities • Immunisation coverage • Supervised Deliveries	Draft National Health Care Financing Policy, National Health Policies & Strategies, HMIS Reports, Annual Health Statistical Bulletins, Joint Review Reports, Annual MoH Reports, Demographic & Health Surveys, Living Conditions Monitoring Surveys, Key Informant Interviews, FGD

4.7 QUALITY ASSURANCE

Several approaches were used in order to ensure internal and external validity. This included:

- Piloting of the interview schedule and SPMRT quick scan before data collection reduced bias due to instrumentation;
- Prolonged engagement of the Key informants and electronic transcription of the responses made it possible to acquire diverse and accurate responses;
- Approaching the research problem from different angles through the use of qualitative and quantitative research was an important technique to gain access to available information through the participation of knowledgeable health managers; and
- Ensuring trustworthiness of the findings by making comparisons with available conceptual literature; feedback from participants in the research; and comments/guidance by my research supervisor.

4.8 ETHICS AND COMMUNICATION

Authorization to conduct the study was granted by the Research Ethics Committee of the University of Cape Town, South Africa (Appendix VI). In addition, the Zambian MoH, acting on behalf of the government of the Republic of Zambia also approved a request to interview

Members of the Health Sector Committee (HSC) as well as to extract information from various government documents (Appendix VII). Before the commencement of each interview, each participant was adequately enlightened on the objectives of the study, interview procedure and specific information that was being solicited for. A written consent was obtained thereafter (Appendix IV). All written and electronic transcriptions that were obtained from the participants were treated with utmost confidentiality and the identities of the participants were not disclosed in any draft or final report of the study. Additionally, no specific comments were attributed to any of the participants.

The anticipated benefits of the study were fully explained to all the participants and assurances were made that they would be availed with a final report on the research findings. It was also expected that all key stakeholders in the Zambian health sector as well as other interested parties would be provided with the results.

4.9 MAIN LIMITATIONS OF THE STUDY

There were five main limitations associated with the study. Firstly, as is the case in most health systems research, it was hard to attribute causality/changes in the health system directly to SWAp and it was only possible to do so indirectly through the use of process–outcome indicators and qualitative judgement. SWAps cannot be held entirely accountable for positive/negative health outcomes since they are merely implemented as part of a broad set of health reforms.

Secondly, the study was conducted at a time when most of the CPs were turning their attention to direct budget support and when the implementing wing of the MoH, the CBoH, was on the verge of being abolished. At the time, morale had slackened and there was a crisis of confidence in the health system. As such, it was possible to have had response bias as some of the interviewees were negatively affected by the decision.

Thirdly, interviewer bias may have been exhibited as all the interviews were conducted by one person who was also an incumbent coordinator of the health SWAp in Zambia at the time of the research.

Fourth, it was difficult to get baseline data (before the SWAp) and between 1993 and 1996 as FAMS and HMIS were not yet in place. Relatedly, extraction of data from different sources i.e. HMIS, population based surveys and several works of other authors might render some results not directly comparable and unreliable.

Finally, SWAps are country specific and are implemented according to donor/government relationships in respective countries. As such, it was difficult to obtain adequate triangulating evidence from other SWAp implementing countries.

CHAPTER FIVE: RESEARCH FINDINGS

5.0 INTRODUCTION

The chapter presents the findings of the research study and is the basis on which conclusions and recommendations for further improving the performance of the health system in Zambia will be made. In analysing the results, qualitative and quantitative research techniques were employed and the inquiry centred on the research objectives and conceptual framework. Verification of some of the findings was made by making references to the literature review and country profile.

Section 5.1 presents in a generic manner, results from interviews and document review, on the Zambian health SWAp. In addition, the section looks at the perceptions on the SWAp coordination process and how the SWAp has enhanced the decentralization process.

Section 5.2 examines in more detail the extent to which each of the individual elements of a SWAp has strengthened mechanisms for aid management, specifically as it relates to stakeholder participation and ownership.

Section 5.3 examines the contributions of the SWAp mechanism as a whole has improving health services delivery in Zambia. The Section is divided in four sub-sections as follows:

- Sub-section 5.3.1 looks at transparency and accountability;
- Sub-section 5.3.2 explores the extent to which the SWAp mechanism as a whole has led to an efficient allocation and use of resources. This includes a review of the level of funding and use of the Basic Health Care Package.
- Sub-section 5.3.3 takes a detailed look at the trends in health care financing, including predictability in disbursements and long term sustainability.
- Sub-section 5.3.4 explores the impact that SWAp has had on improving the health status of Zambians specifically if it has improved geographical (urban/rural) equity of access to health care resources.

Section 5.4 presents a brief summary of the key findings.

5.1 THE ZAMBIAN HEALTH SWAP

5.1.1 Knowledge on the Zambian Health SWAp

Key Informant Interviews revealed high levels of knowledge on the Zambian Health SWAp, which were in agreement with the document review undertaken for this study. In assessing their knowledge, respondents were asked about the genesis of the health SWAp and the specific objectives that necessitated its adoption in Zambia. Generally, respondents affirmed

that the Zambian health SWAp commenced in 1993, way before the first SWAp guide for health development was presented in 1997 and prior to the adoption of SWAp as an important approach to sector investment lending by many development agencies. Most of the respondents noted that the Zambian Health SWAp process developed naturally having first been implemented at district level. The implication of this is that though the dialogue become sector-wide with time, the mechanisms for the SWAp were focused at district level. Indeed, the entire structure of the SWAp arrangement in Zambia is to a large extent still built around the districts.

Several interviewees regarded the Zambian health SWAp as a process whose genesis was well-timed and which couldn't have been implemented at a better time. According to them, its adoption signified a strong and commonly shared sense of purpose and commitment to rebuilding the health sector after the turmoil of the second republic. Box 1 summarizes the main shared visions for the Zambian Health SWAp.

Box 1: Basic Features of the Zambian Health Sector SWAp

i. A long term commitment to the health vision
ii. Articulation of a clear, practical medium term National Health Strategic Plan
iii. Support to a defined cost-effective Basic Health Care Package of interventions
iv. Support to a "Common Basket funding"
v. Commitment to the Memorandum of Understanding (MoU)
vi. Joint planning and review of strategic plans
vii. Joint procurement, disbursement, reporting, accounting and audit systems and procedures

Source: Kalumba and Musowe, 1996; Phiri, 2003

5.1.2 Coordination Process

A close scrutiny of the Zambian health SWAp model reveals that it is a combination of modalities for sector dialogue, pooled funding arrangement, and joint planning and implementation. Thus, there are essentially four main structures that effectively coordinate the health SWAp process in Zambia. These are:

i. MoU (discussed in 5.2.1.2) between the MoH and its CPs. It should be noted that the MoU actually governs the SWAp process as all the structures outlined below are enshrined in the MoU itself.

ii. SWAp coordination meetings (Minister's and Heads of Missions Policy Meeting; Annual Consultative Committee Meeting; Health Sector Advisory Committee Meetings; Monthly Policy Meetings; Monitoring and Evaluation Committee Meetings;

Implementation Review Steering Committee Meetings; and various Technical Committee Meetings);

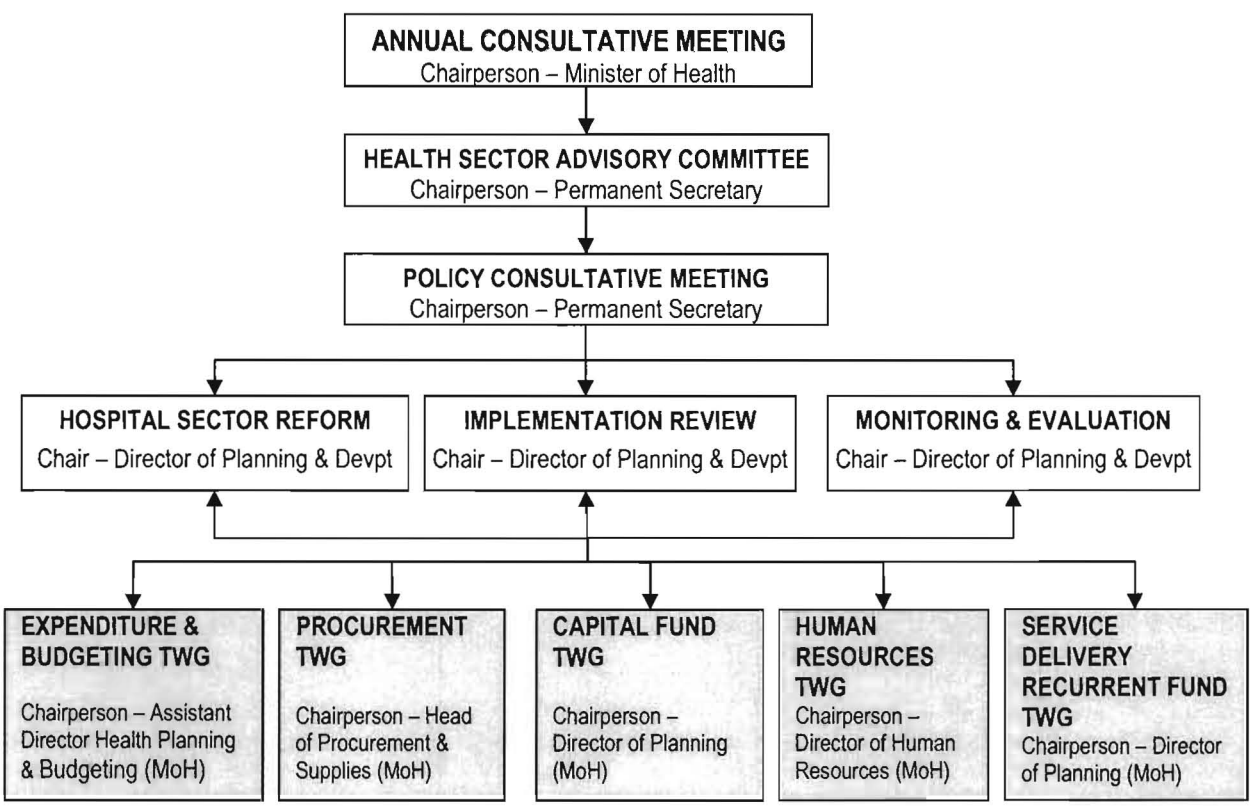
iii. Popular participatory structures at community, district and hospital levels which support decentralised authority to manage health services; and

iv. Health Sector Joint Review Missions.

5.1.2.1 SWAp Coordination Meetings

A pictorial view of the hierarchy and linkages between the various SWAp coordination committees is provided in Figure 5. At the helm of the SWAp collaborative process are three (3) core steering committees (Annual Consultative Committee Meeting, Health Sector Advisory Committee Meetings and Policy Meetings) which are chaired by either the Minister or Permanent Secretary. In order to spearhead the implementation process, three sub committees namely: the Hospital Sector Reform Steering committee, MoH/CBoH Implementation Review Steering Committee and the Monitoring and Evaluation Committee are in place. These sub committees are supported by several technical working groups whose existence is to enable technical level discussions between MoH, CPs and other stakeholders in the health sector.

Figure 3: SWAp Coordination Meetings



Observation of four different SWAp co-coordinating meetings revealed that there is a great deal of information sharing, priority setting, programming and policy making. However, some

of the interviewees pointed out that the SWAp in the health sector in Zambia was more of an approach to policy making and to a lesser extent, to programming. In this case, policy making was regarded as a process of analysis, decision making, implementation and evaluation.

Appendix I provides a full description and composition of all of the SWAp coordination meetings highlighted above.

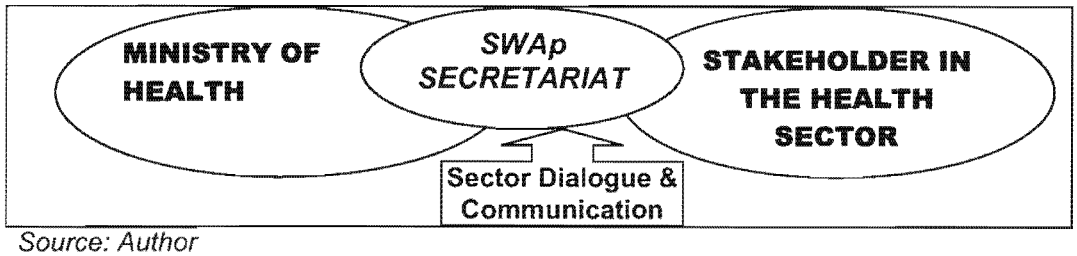
5.1.2.2 Day to Day Management of the SWAp Coordination Process

For purposes of handling day to day business in the SWAp, a SWAp coordinating secretariat was established in September 2003 after a realisation that effective communication was a critical requisite for health sector dialogue. The establishment of the SWAp coordinating secretariat came after increased pressure on MoH staff to meet the additional administrative functions created by the SWAp process. Thus, the SWAp coordinating secretariat is housed at the MoH and its main responsibility is to ensure that the health SWAp is effectively coordinated through the four main structures that are enshrined in the MoU".

Generally, interviewees expressed satisfaction with the coordination process for the SWAp in Zambia, including the SWAp secretariat. Several interviewees that were questioned about the management of the Zambian Health SWAp acknowledged that the establishment of the SWAp coordinating secretariat had tremendously improved communication and dialogue in the health sector. One such comment was made by a bilateral CP as follows: *"The SWAp has been a revolving process that is getting better. With time CPs have been instrumental in beefing up the capacity of MoH more so by putting in place a SWAp secretariat. I think the way that SWAp meetings are managed now and even the way that documentation is done is a lot better than the situation I found. This has helped to streamline the decision-making processes and one could be quite happy to be associated with such".*

This sentiment was also echoed during the mid term review of the NHSP 2001–2005 where it was asserted that there is intensive dialogue and communication between CPs and MoH/CBoH as a result of the effectiveness and dedication of the SWAp coordinating secretariat (Ministry of Health, 2003). However, even though the SWAp coordinating secretariat has been recognized as a key unit in MoH, it is not yet institutionalized within the main government structure.

Figure 4: Day to Day Management of the SWAp Collaborative Process



Source: Author

5.1.2.3 SWAp and the Decentralisation Process

It was established from Key Informant Interviews that popular participatory structures at district and community levels link the SWAp to the decentralisation process. The popular structures are run by both health professionals and the general populace and these include District Health Boards (DHBs), Hospital Management Boards (HMBs), Health Centre Committees (HCCs) and Neighbourhood Health Committees (NHCs). Brief descriptions of these structures are provided in Appendix II.

Interviews with key stakeholders on the synergy of the Zambian health SWAp with the decentralisation process revealed that it had to a larger extent greatly benefited from, and complemented the decentralisation process at district level.

5.2 ANALYSIS OF INDIVIDUAL ELEMENTS OF A SWAp

The five core elements of a SWAp as presented in the conceptual framework (Figure 2) are:

- Government stewardship in a sustained partnership with all stakeholders
- All significant funding agencies support a shared, sector wide policy and strategy
- A MTEF or budget which supports this policy
- Commitment to move to greater reliance on government financial management and accountability systems
- Shared processes and approaches for implementing and managing the sector strategy & work programme

It is understood that implementing each of the five elements of a SWAp would strengthen mechanisms for aid management. In assessing the status towards the implementation of the individual elements of the health SWAp, qualitative data more especially the Key Informant Interviews and the SPMRT though the FGD were relied upon.

5.2.1 GRZ Stewardship and Sustained Partnership with all Stakeholders

5.2.1.1 Sector-wide or sector-narrow

5.2.1.1a Stakeholders Participation in the SWAp

As discussed earlier, MoH organises several SWAp coordination meetings, which are ideally supposed to involve the participation of all stakeholders directly involved in the health sector including MoH and other line ministries, CPs, NGOs, and consumers. Findings from the research pointed to the fact that the Zambian Health SWAp had for a long time not been widely inclusive. Several respondents observed that line ministries such as the Treasury, Education, Community Development and Social Services, NGOs, the private sector and consumers were not involved in the upper echelons of SWAp consultative meetings where policy issues were discussed. A critical look at the attendance lists contained in the minutes of key SWAp meetings from 2002 to 2005 also revealed that most of the participants (100 in total) were CPs (both bilateral and multilateral), MoH and affiliated Statutory Board/Bodies, and tertiary level hospital management boards based in Lusaka. The only NGOs that were involved at all fora were the Churches Health Association of Zambia (CHAZ) and three USAID affiliated NGOs/projects. From time to time, GFATM also sent in its regional representative.

Up until March 2005, the civil society was also not part of the SWAp because MoH felt that a wider audience would imply a public meeting, which may become political and futile. The emphasis by MoH was on the need to be focused during the SWAp meetings even though it acknowledged the importance of wider stakeholder participation (*Key Informant Interviews*). With increased pressure from other stakeholders in the SWAp, the civil society was consequently co-opted into the SWAp consultative process even though their level of participation in terms of numbers and contribution during the meetings are still very minimal.

One meaningful observation can be made relating to the respondents' answers on minimal stakeholder participation in the SWAp. Firstly, the inability to have all the key stakeholders on board raises questions on the ownership of the SWAp process and impartiality in policy formulation and resource allocation. The absence of key stakeholders means that they are not sufficiently acquainted with the health sector and as such there is inadequate participation.

5.2.1.1b Range of Activities Supported by Pooled Funding

According to the perspectives of the key informants, the Zambian health SWAp is sector narrow towards the public sector and also within the public sector itself to an extent whereby people only equate it to pooled funding. The indication is that the health SWAp is not a full SWAp because the basket doesn't cover the full range of activities vertically and horizontally.

One of the key informants explained that the health SWAp has only satisfactorily operated half of the time that it has been in existence even though it has been in implementation for over 10 years. It was argued that the build up to sector-wide was halted during the period 1997-1999 when partnership problems were experienced. During this period, there was insufficient political support to an extent whereby the SWAp wasn't really being implemented with commitment by MoH.

After the 1997-1999 period of stagnation, confidence was restored and the SWAp was back in full swing. This led to the expansion of basket funding to include other levels of health care. However, even with the expansion of the basket, the general feeling is that the SWAp is still sector-narrow in the range of activities supported by pooled funding and that it needs to be further expanded, vertically and horizontally. Views of the respondents on the matter are outlined in Box 5.1 below.

Box 5.1: Key Informants on Stakeholder Participation and Range of Activities Supported

***Bilateral CP**: "The health SWAp is evolving to be sector-wide but is not sector-wide at the moment. A number of stakeholders are not coordinated during the planning process due to low negotiation power by MoH".*

***Bilateral CP**: "SWAp reinforces national systems and tries to promote transparency and accountability. What is important is that even if there is transparency and accountability, people who are actually using the service voice out to indicate the type of service they are getting (good or bad). A system for tracking consumer perceptions is not in place and consumers cannot voice out. The voicing part is somewhat advocated for by calling for improved communication by Users, NGOs, popular structures etc but this is not enough. SWAp is not a one way ticket to get rid of corruption".*

***Bilateral CP**: The Zambian health SWAp is not a full SWAp. There is need to have a full SWAp to address all the key areas especially human resources. Until we start supporting all critical areas, we will achieve nothing. A SWAp should support the full sector - it's supposed to be sector-wide. What we have is a district and hospital SWAp and further within that only a few cost items are addressed. It's not a full SWAp in terms of horizontal and vertical dimension. Need to go all the way if you expect to achieve more".*

***MoH Official**: "The SWAp supports all activities contained in annual action plans except for certain cost items like personal emoluments. Further, ceilings are put on how much money is to be spent on drugs, capital, allowances and so on. In this sense, the SWAp is not really a full SWAp more so that critical things like human resources are not covered".*

***Academia**: "Involvement in SWAp implies everyone supporting the health system is supporting SWAp because the health system adopts the SWAp. But this is a different definition for those who are providing their support in a way that is most conducive to a SWAp i.e. basket funding".*

5.2.1.2 Stakeholder Ownership of the SWAp process

Ownership of a process goes beyond mere participation and in this study, stakeholder ownership of the SWAp process was assessed by looking at both the level of stakeholder participation in the SWAp consultative process and the quality of the interaction. Thus, in terms of the level of involvement, or probably the number of CPs that were committed to the SWAp at inception, an attempt was made to look at how many CPs had signed the 1999 Memorandum of Understanding (MoU) out of the total number of CPs that were targeted. Secondly, the number of CPs contributing to basket funding (pooling CPs) and those that weren't contributing to basket funding (non-pooling CPs) but merely participating in the SWAp consultative process were looked at. The next step was to find out if the non-pooling CPs are accorded an equal voice in the SWAp consultative process.

The MoH successfully managed to commit thirteen (13) CPs to the health SWAp out of fifteen (15) CPs that were operating in the health sector at the time of signing the MoU in 1999. Though not a legally binding document, commitment to the MoU laid the foundation for fostering partnerships towards the attainment of the health vision. The MoU centres on how the SWAp should be governed through common management arrangements and is not a regulatory tool of how business in the SWAp should be conducted. A Code of Conduct (CoC) that was to regulate the way business is conducted in the SWAp was drafted in 2003 but it didn't come to fruition.

In terms of compliance with the MoU, this element is only partially accomplished. Though the MoU clearly stipulates that the preferred mode of financial support to the health sector is through basket funding, a review of the number of CPs contributing to the basket indicated that the number only increased from five in 1993 to nine (the highest number since the inception of the health SWAp) by 2003. This implies that while the number of CPs subscribing to the MoU was 13 in 1999 only 9 of these were actually pooling resources by 2003. A further review of the situation in 2006 showed that the number of CPs contributing to the basket actually dropped from nine (9) in 2003 to seven (7) in 2006. This can be attributed to the shift by some CPs to Direct Budget Support (DBS) and/or withdrawal of mandate by certain CPs. While the transition to DBS might not be regarded as loss of confidence in the SWAp, the latter fairly depicts a loss of confidence in the SWAp.

Table 6 below highlights the number of CPs that committed themselves to the MoU and the number contributing to the pooled fund.

Table 6: Commitment to the MoU and Pooled Funding

Number of CPs operating in the health sector at the time of singing the MoU in 1999 (1999 estimate)	Number of CPs who actually signed the MoU in 1999	Number of pooling CPs at the time of signing the MoU in 1999	Highest number of pooling CPs after the signing of the MoU in 1999 (2003 estimate)	Number of pooling CPs withdrawing from pooled funding for any other reason other than shift to DBS (2006 estimate)
15	**13 out of 15**	**5 out of 15**	**9 out of 19**	**2 out of 19**

A number of reasons can be given for the small number of CPs that are pooling resources in the Zambian Health SWAp. One of the overriding reasons was provided by a Multilateral CP who noted that *"Certain CPs are not pooling resources because the NHSP is not comprehensive enough to attract all stakeholders on board. The health SWAp process in Zambia still operates in a project mode and some CPs consider it to be one of their many projects. Sometimes luck is on the government side as some CPs would provide money to the pool while at the same time also support vertical programmes. Other CPs only provide support through projects".* Relatedly, it was leant that certain CPs do pool resources in other neighbouring countries but don't do so in Zambia and this to some extent means that there is less confidence in the Zambian health SWAp. One such CP is the World Bank which makes flexible contributions to the pooled funding arrangement in Malawi but only provides earmarked funding through projects in Zambia.

Though it is understood that a SWAp is not equal to pooled financing, there is so much preoccupation about pooling resources in the Zambian health SWAp that if a CP doesn't pool resources, that CP is considered to be not SWAp-minded. For example, respondents considered JICA and USAID as not being SWAp-minded because they mainly provide their support through projects. This is despite their programmes and activities being drawn from the NHSP. In addition, though some CPs have a modified way of providing support to the basket, like USAID through the Sector Programme Assistance (SPA), they were still considered to be not SWAp-minded because their contribution to the basket was far less than project support. This phenomenon is manifested in the health sector to an extent whereby the non-pooling CPs feel they are not part of the SWAp and this ultimately affects their commitment and ownership of the SWAp process.

An evaluation of whether the non-pooling CPs were accorded an equal voice in the SWAp consultative meetings was done and most respondents indicated that the non-pooling CPs were active participants and not just mere observers like in other countries. However, it was pointed out that though the non-pooling CPs had an equal voice, their voice was less influential as compared to pooling CPs. It was also advanced that the pooling CPs were closer as allies to MoH than the non-pooling CPs (see Box 5.2).

Box 5.2: Key Informants on Stakeholder Ownership of the SWAp process

Bilateral CP 1 *"Non-pooling CPs are active participants and not just observers like other countries. They are able to speak freely on what they like but its up to the meeting to weigh their comments vis-à-vis other comments in the meeting. In this sense they have an equal voice. But to what extent are the non-pooling CPs influential with that equal voice. By and large the CPs who are more SWAp-minded (pooling CPs) tend to have a more influential voice. This is not because of the way they provide support; it is more because of the content of what they say. By the nature of their assistance they are supporting the SWAp because they are putting money into the basket and look at GRZ in terms of everything that they say and do. They pay particular attention to GRZ reports and they have the strongest of incentives for GRZ to work as effectively as possible, for GRZ to be transparent as possible, for GRZ capacity to be as high as possible. Their focus on development systems is on GRZ. So when they are in their offices they are thinking about GRZ, when they are in meetings they are thinking SWAps, when they are in discussion they are thinking about SWAp. When you are not pooling, your concern is the projects, you think of project financial accountability, project expenditure, project effectiveness, impact, project M&E systems. So you focus inwards to the projects and not thinking day in day out about the MoH & health sector. So when you come to HSC meeting, your comments won't be so much considered. If you only have time to read one report per month it will probably be a report about a project and not a report about a SWAp or the Zambia health sector".*

Bilateral CP 2 *"CPs that pool resources are far closer as allies to MoH and they are far closer aligned in their thinking and in their ideologies and in their problem solving capacity. As such, the content of what they say tends to be far much more considered and far more appropriate. Because of this, it has a snowball effect. If senior MoH officials want to consult CPs on some health sector issues. Whom do they turn to first? They turn to those who are more in tune with their own thinking and whose content they have far higher respect for. And these are the pooling CPs (basket funders)".*

5.2.1.3 Government Ownership of the SWAp process

In a SWAp, government is supposed to guide the SWAp coordination process by providing adequate leadership and by being the steward. Effectiveness of GRZ in the SWAp coordination process was assessed by looking at how the power relations between MoH and CPs influence practice, specifically the extent to which MoH makes the key decisions or is dictated to by the CPs. Lastly, there is a detailed look at the quality of the consultative process.

Several CPs that were interviewed about the adoption of the SWAp in Zambia clearly indicated that the MoH had provided the requisite leadership and power that took forward the SWAp process. One of the Multilateral CPs pointed out that the impetus for health reforms and movement to the health SWAp was enshrined in the MMD manifesto and that the policies and strategies that were developed encouraged CPs to give up resources to government and to act/do things that were sector wide. This view was supported by a Bilateral CP who observed that adoption of the SWAp process was very much Zambian and that from 1991, all the CPs that were willing to provide support to the health sector knew what they were getting

into. Further, another informant, this time a MoH official, indicated that MoH was well-ahead in the implementation of the health reforms and the SWAp while the CPs followed behind.

But to what extent has GRZ sustained its leadership role in practice? The key informants provided no clear cut answer on this question but pointed out that power relations between MoH and CPs have in practice been influenced by changes in manpower, both on the MoH and CPs' sides. The reasoning behind this line of argument is that key officials from MoH and CPs who championed the cause were moved at a very early stage and this pushed the SWAp process backwards. It was explained that new entrants in the health sector failed to sufficiently push the health sector reform continuum forward. These comments can be substantiated by the fact that the development of the health SWAp was conceptualized within the broader health sector reform agenda and as such, its implementation hinged on the willingness of office bearers (MoH and CPs) to push the process forward. In this regard, five phases can be clearly distinguished which reveal varying degrees of MoH/CPs power relations since the inception of the health SWAp and this is provided in Appendix III.

Despite the various changes in MoH/CPs power relations during the SWAp implementation period, key informants indicated that the decision making process had improved in the last 3 years prior to the research. It was stated that the decisions that were adopted were more consultative and transparent. Several Informants were happy with the culture of minuting action points and decisions reached in SWAp meetings and following up on them. The indication was that 90% of the times, decisions reached on consensus were adhered to. If not, at least there was agreement on who was responsible.

However, it was noted that even though the quality of the consultative process had improved, power relations were complex and that the relationship between MoH/CPs shifted according to the matter at hand. As a result, even if MoH seemed to be driving the process, in most cases the CPs had an upper hand when it came to making major decisions. Respondents felt that some CPs' comments during SWAp coordination meetings brought far-reaching repercussions beyond which one could imagine and that this greatly influenced the power relations. In certain instances, CPs make decisions without involving GRZ and other stakeholders in the SWAp. A case in point is the decision by some CPs to start providing support through Direct Budget Support (DBS) through the Ministry of Finance and National Planning (MoFNP). Non-participant observation of the 2005 Annual Consultative Meeting clearly demonstrated that the transition to DBS was not favoured by MoH. Yet, the CPs in question appeared to have had no regard for MoH as they were merely executing the policies of their missions which are keen to channel support through DBS. While it is appreciated that DBS gives absolute power to the recipient government to allocate resources and to take responsibility of key sectors in the economy, the transition to DBS is probably one of those

decisions that CPs implemented without regard to MoH. This reflects that MoH is not in complete control even though it is in the leadership role. Box 5.3 presents some of the comments on the decision by some CPs to transit to DBS.

Box 5.3: Key Informants on Transition to Direct Budget Support

"The shift from SWAp to DBS is a natural progression but the way we move in Zambia is too fast. We always move too fast. It's not a bad idea but if you fail you fail badly. We needed to improve the sector SWAps, perfect the SWAp, even before we move to DBS because we need the key ingredients of a SWAp to be able to manage DBS. Not sure if we are ready. But the other side of the argument is that you learn by doing. Thus, you need to be involved in the system before you can actually make an incredible impact. In a crude fashion you build systems as you work. But I am not comfortable with the move to DBS". ***Bilateral CP.***

"In reality, you have funders on one hand and a receiver in the other hand. Though government is in the driver's seat sometimes it is pushed against the wall". ***Multilateral CP.***

"In a climate of scarce resources, whereby 40 to 60% of the national budget is covered by external sources, it's difficult for government to be in complete control". ***Multilateral CP.***

At several fora, the CPs do emphasize the need to implement sound decisions. However, one wonders if the shift to DBS is a sound decision. A recent review of public expenditure and financial accountability in Zambia (World Bank, 2003) pointed to the lack of well-developed sector policies and coherent working arrangements in most of the line ministries as well as low public expenditure management at the Ministry of Finance and National Planning (MoFNP). As such, there is no justification in giving the full powers to MoFNP to allocate resources given its low public expenditure management. In fact, it seems that there is no national ownership of the decision to transit to DBS as even officials at MoFNP don't fully understand the concept.

Apart from making certain decisions without involving GRZ, the CPs have sometimes been accused of not adhering to decisions passed during SWAp consultative meetings. This was highlighted during the Health Sector Committee meeting of 30th September 2004 where the CPs had flouted the decision that had been made during the August 2004 Policy Committee Meeting (PCM) to commence funding more eligible institutions as well as to increase funding to districts. The failure to respect the resolutions of the PCM undermined the authority vested on the PCM as the policy making body of the SWAp.

On the other hand, the key informants argued that the desire of the CPs was for GRZ to be more transparent in policy and resource allocation in which instance there would be no need to intervene or to question how the decisions were made. The point is that when GRZ makes certain decisions which are not in line with the requirements of the SWAp, CPs naturally questioned the process. One of the Bilateral CPs was empathic on this issue and observed that:

"If you give money to GRZ, you expect reports so that plans are based on sound information. CPs are frequently let down and disappointed on this one. In most cases the CPs are not consulted on the MTEF and how resources are allocated. Often there is agreement about key events in the sector that CPs that provide significant basket support rely on. When GRZ doesn't provide these, CPs are disappointed. It is difficult to approve additional resources to health sector and ironically, the CPs that provide money to the basket boast of how good the SWAp is in Zambia. Their judgment is questioned & embarrassed when GRZ doesn't provide reports. Thus, a lot is at stake for CPs to support a SWAp when GRZ doesn't perform. Sometimes CPs offer to provide Technical Assistance but GRZ usually refuses citing use of local capacity and systems. But what confidence does the CPs have that GRZ will perform as agreed. So, whilst GRZ has demonstrated it has capacity limitations it is unwilling to strengthen its capacity which again undermines confidence and progress. Though ownership is very important and that it shouldn't be undermined, a balance needs to be struck. It seems that the reasons for MoH wanting to have ownership is more important than progress".

In summary, it is apparent that though government provides leadership in the SWAp process, it is not completely in control as it doesn't fully sanction some of the key decisions. This, to some extent, depicts relatively fair government ownership of the process. CPs sometimes dictate the process either in the interest of making sure that the set objectives are met or to meet the mandate of their missions. However, if one critically assesses this situation, it actually means that CPs do influence policy and resource allocation, which is in fact what we want the SWAp to do so that pro-poor policies are put in place. The only problem that comes is that the pooling CPs are the ones who are mainly influencing this policy in Zambia whilst the other stakeholders in the health sector are not sufficiently doing so. This can lead to the implementation of biased policies.

5.2.2 Support towards a shared sector wide policy and strategy

According to officials from the MoH, the National Health Policies and Strategies of 1992 set the logical argument for embarking on health reforms and adoption of the health SWAp. It was indicated that the actual development of the document was done by MoH and presented for consensus building to all stakeholders at a meeting in Livingstone, Zambia in 1991. The understanding is that CPs joined into the development of the document at a later stage but they pledged to provide support towards the policy given the positive nature of the document. What has followed since the adoption of the National Health Policies and Strategies has been the development of several National Health Strategic Plans (NHSPs). In entirety, four (4) NHSPs have been developed since the commencement of the Health Reforms in 1992. The first plan covered the period 1995-1999 (but only operationalised from 1995 to 1997); the

second plan covered the period 1998-2000; the third plan covered the period 2001-2005 and the recently developed plan to cover the period 2006-2010.

Responding to a question over commitment of support towards the sector wide policy and NHSPs, several respondents indicated that all stakeholders operating in the health sector drew their programmes and activities from the National Health Policies and Strategies but not the NHSPs. It was explained that most CPs were not comfortable with most of the NHSPs that had been developed before 2001 and that the NHSP 2001-2005 was the only one that had been comprehensively developed with consensus from most CPs. The development of the NHSP 2001-2005 did in fact benefit from the Joint Identification and Formulation Mission of 1999/2000.

Thus, the number of CPs providing support to the NHSP increased with the development of the NHSP 2001-2005. However, as shall be explained in section 5.2.5, certain CPs were still not providing support towards the NHSP. One of the major reasons that was advanced by the respondents was the existence of several financing mechanisms and failure of GRZ to harmonise and align all significant funding towards the NHSP. The other reason that was put forward was that the NHSP 2001-2005 had not been fully costed and that it had no logical framework (master implementation plan). This made it difficult for stakeholders and programme managers to translate and timely implement the broad strategic objectives and goals. The means of verification were also not explicit enough for implementers to define and measure health outputs/outcomes.

5.2.3 Medium Term Expenditure Framework (MTEF)

One of the prime elements of a SWAp is that there should be a comprehensive MTEF supporting the sector-wide policy and that it should focus on all aspects of the health sector. Unfortunately, ten years (1993-2003) after the inception of the health SWAp in Zambia, there was no government MTEF that linked policy, planning and budgeting in all the line ministries, including MoH. As such, it was difficult to predict funding from one year to the next and within one budget year. As one respondent observed, lack of an expenditure framework made it difficult to project the total resources that were available from all sources and to allocate resources to strategic priorities between and within sectors. Lack of a medium term focus for resource planning also made it hard to plan ahead for changes in policy and expenditure reallocations.

Realising that the NHSP (2001-2005) could not be adequately implemented without a full picture of financial pledges and commitments, MoH and its CPs developed a Joint Investment Plan (JIP) in 2001 with the idea of improving efficiency in the use of budgeted resources. When asked about the operationalisation of the JIP, the respondents, however, indicated that

the JIP was never used during the development of annual action plans and budgets as both the CPs and government were not disbursing monies as stipulated in the JIP.

The government eventually introduced the MTEF in 2003, the first of which was developed for the period 2004-2006. Subsequent MTEFs were developed for the periods 2005-2007 and 2006-2008. In Zambia, the MTEF is a three-year framework within which available resources (both Government and donor) are divided between sectors on the basis of achieving government objectives. The main aim was to address weaknesses in the planning and budget processes by ensuring that resources were efficiently allocated and managed; maintaining of fiscal discipline in planning and management of public resources; and to improve predictability of resources.

The extent to which the MTEF has addressed weaknesses in planning and budgeting was discussed in the FGD and interviews with key informants. Generally speaking, most of the responses felt that the budgeting process was still weak and that the total health sector resource envelope was not fully known. As such not all the planned expenditure and projects are captured in the MTEF and MoH is not fully able to make informed decisions about the overall allocation of resources to priority programmes and activities. The existence of three (3) financing mechanisms, as shall be presented in Figure 5 below has not helped matters as most of the funding sources are not aligned to the MTEF and NHSP. Thus, in reference to what is being tested in the conceptual framework, one can argue that the MTEF as an element of the SWAp was not really effective in strengthening mechanisms for aid management despite it being integrated with the policy process.

5.2.4 Use of GRZ financial management and accountability systems

It was clearly established from the FGD, key informants, non-participant observation and document reviews that the SWAp had strongly encouraged the use of GRZ financial management and accounting systems mainly among the CPs pooling resources. The extent to which this has encouraged transparency and financial accountability is discussed in Section 5.3.1

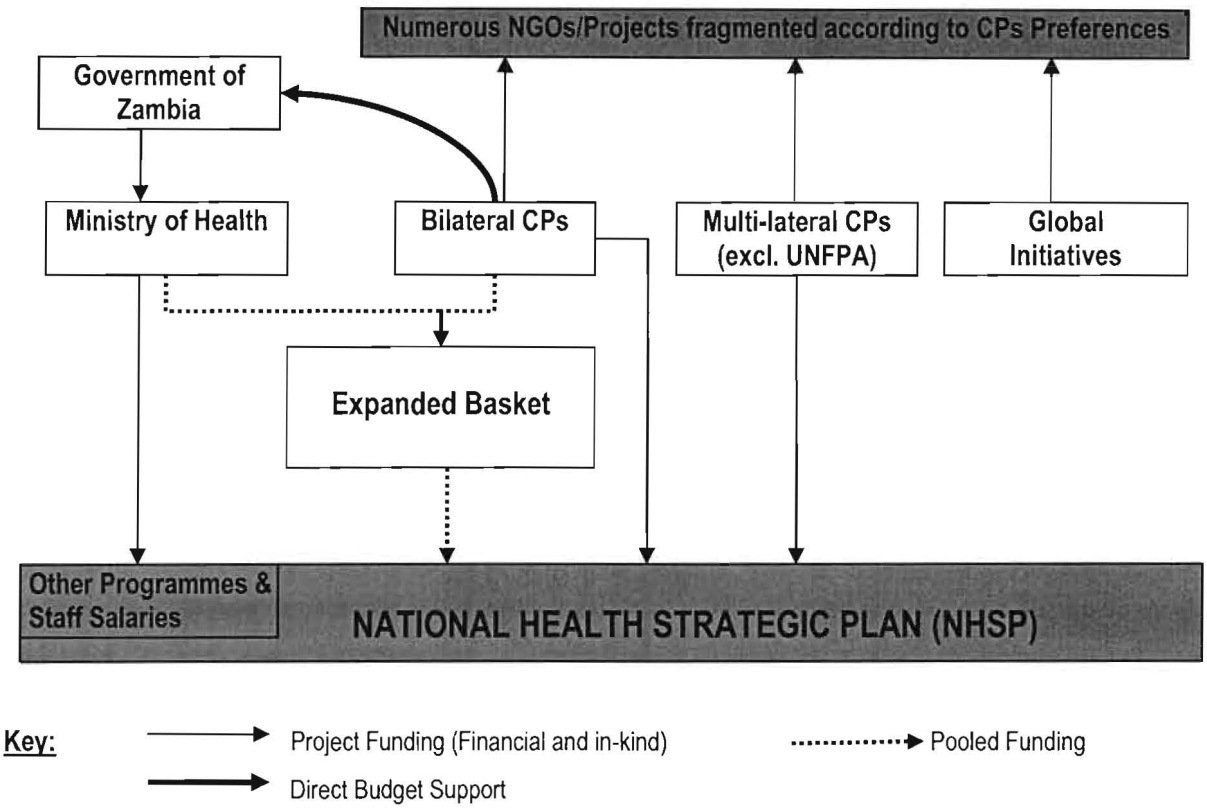
5.2.5 Common approach to implementation and management

The Institute for Health Sector Development (2004) refers to the above element of a SWAp as the plumbing component that is driven by all the other elements of the SWAp and that the plumbing component itself should support all the other elements of a SWAp and not vice versa. Ideally, a common approach to implementation and management means the use of harmonised funding, accounting, auditing, procurement, reporting, and monitoring and evaluation procedures.

5.2.5.1 Financing Mechanisms

Figure 5 below illustrates the prevailing financing mechanisms in the Zambian health SWAp as at March 2006.

Figure 5: Financing Mechanisms in the Zambian Health SWAp



Three (3) modes of support were in existence namely; pooled basket funding, project funding and direct budget support. The number of pooling CPs (including MoH) was eight (8) during the year 2005. These were SIDA, DGIS, DANIDA, DFID, DCI, USAID, UNFPA and MoH. Most of the pooling bilateral CPs were also providing support to NGOs through projects in addition to the monies that they were providing to the basket. This includes DGIS, DCI and USAID. Certain bilateral CPs like JICA and CIDA were providing in-kind support through projects and all their activities were drawn from the NHSP.

All the multi-lateral CPs (except UNFPA) were providing support through projects with all their programmes/activities drawn from the overall NHSP. On the other hand, global health initiatives (GFATM, PEPFAR, GAVI, BUSH Foundation, Bill and Melinda Gates Foundation etc) were also providing support through several projects and NGOs but most of their programmes/activities were not drawn from the NHSP. In terms of Direct Budget Support through the Ministry of Finance and National Planning, the only CP that was using this mode of support in 2005 was EU but it was later joined by DFID in 2006.

The existence of three (3) financing mechanisms as highlighted above has a lot of implications for efficiency as earlier explained. One of the bilateral CPs was very emphatic on this issue and had this to say. *"It must be appreciated that pooling has to do more with accounting and that the real inefficiencies come in when some CPs don't share plans, budgeting and reporting systems. Thus, lack of harmonization and alignment of aid to the overall plan is contributing to inefficiency and loss of focus in the SWAp far more than money being in the pool. However, if all these monies were pooled, it could have been possible to use joint systems even though the ideal case would be to share plans and to align funds to the budget".*

The existence of 3 modes of financing in the Zambian health SWAp points to the commonly held view that if there are several financing mechanisms, then the focus of the SWAp is lost.

5.2.5.2 Accounting, Auditing, Procurement and Reporting Mechanisms

The adoption of the health SWAp necessitated the development of joint accounting and reporting systems that include the Financial and Administrative Management System (FAMS), the District Integrated Logistic Self-Assessment Tool (DILSAT), Health Management Information System (HMIS) and SWAp coordination meetings.

The establishment of the FAMS and HMIS has made it possible to routinely review the implementation of activities in the Zambian health SWAp vis-à-vis fiscal discipline and service delivery. The FAMS and HMIS are operational in all the 72 districts in Zambia and some of the tertiary hospitals. The actual reviews are done during the SWAp coordination meetings (particularly the Health Sector Advisory Committee meeting) where a 'basket' report detailing the financial flows, expenditure, audits, debt position and selected HMIS indicators are provided.

In addition to the above, Joint Annual Reviews (JARs) were introduced in the Zambian health SWAp in October 2004. The intention of the JARs was to allow all stakeholders in the health sector to experience field realities and to gain a better understanding of progress regarding service delivery. The introduction of the JARs counteracts the commonly held view that SWAps reduce the need for fieldwork and CP missions' sense for work on the ground. The expectation is that the JARs would further harmonise CPs supervisory visits in the health sector.

Apart from the routine reviews and the JARs, the SWAp also accommodates joint independent reviews and between 1992 and 2006, five (5) joint appraisals of the health sector reforms and three Demographic and Health Surveys (DHS) have been conducted in Zambia. This includes the Independent Review of the Zambian Health Reforms (1996); Joint Identification and Formulation Mission (2000); Joint Health (Pre) Appraisal Mission (2001);

Mid Term Review of the NHSP 2001-2005 (2003), Institutional and Organisational Appraisal of the Health Sector (2004); DHS (1992); DHS (1996); and DHS (2001/2002). At the time of the research, MoH and its CPs were working out modalities for conducting the DHS 2006. The DHS is a population based survey on demographic and health issues that is conducted every five (5) years in conjunction with the central statistical office.

Most of the interviewees appreciated that the use of joint systems had to a great extent strengthened mechanisms for aid management but they aired their displeasure over the CPs that were using separate systems. It was pointed out that certain CPs like USAID, World Bank, GFATM, PEPFAR etc were using separate plans, budgets and reporting formats leading to administrative inefficiencies.

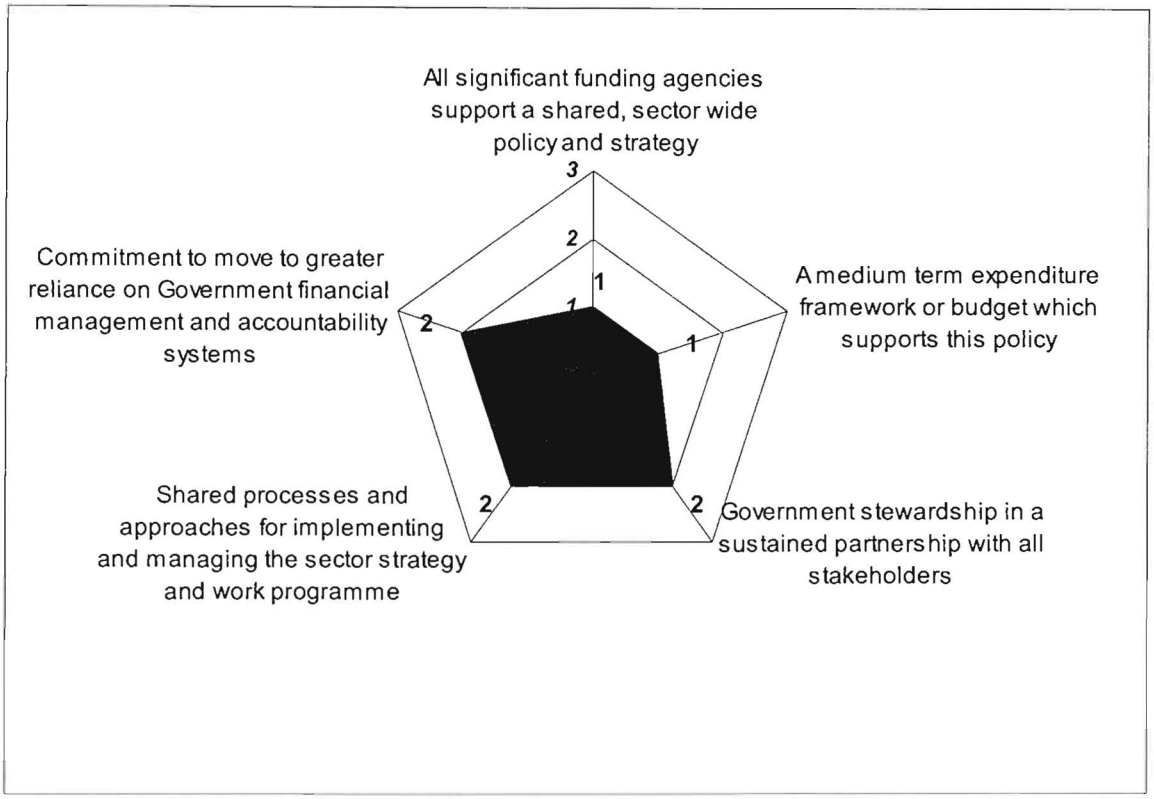
In terms of procurement, the respondents indicated that there were no synergies in the financing and procurement of drugs to an extent whereby the health sector could not take advantage of bulk procurements through the International Competitive Bidding (ICB) process and framework contracting. Framework contracting requires the prior selection, registration and classification of capable firms that would undertake the procurement of goods and services at given time periods though a framework where the thresholds, quantification, selection, costing, packaging and quality of the products are stipulated. Framework contacting can improve the management of the procurement cycle as it cuts down on the procurement lead time.

Due to lack of synergies in the financing and procurement of drugs, the procurement of drugs hasn't been well coordinated and is inefficient. Ideally, it was envisioned in the National Drug Policy (NDP) of 1997 that a "Drug Supply Fund" (jointly funded by GRZ and CPs) for the procurement of drugs would be established but by March 2006, this had not yet materialised. However, at the time of the research, efforts to operationalise the Drug Supply Fund were underway and in January 2006 a manager of the fund was appointed.

5.2.6 Summary

Figure 6 below, summarises the extent to which the Zambian Health SWAp has achieved the five core common elements of a SWAp as outlined above. All characteristics of a SWAp exist in the Zambian health SWAp but with varying degrees of realization. Furthermore, there are also certain innovative features that have been introduced like the SWAp coordinating secretariat and numerous technical working groups.

Figure 6: Achievement of the five Core Common Elements of a SWAp



Maximum possible Score = 3. 0=Not Achieved; 1=Partially Achieved; 2=Substantially Achieved; 3=Fully Achieved

5.3 ANALYSIS OF THE SWAp MECHANISM AS A WHOLE

As conceived in the conceptual framework (Figure 2), the mechanism as a whole should *strengthen the health system leading to better health outcomes*. In examining the effectiveness of the health SWAp as a whole, an effort was made to look at the contribution of the health SWAp to improved transparency and accountability; efficiency (administrative, technical and allocative); financial sustainability and geographical equity of access.

5.3.1 Transparency and Accountability

Good governance and accountability are key to economic growth and a health system that customarily addresses these issues can go a long way in providing the most for the people that it serves. As indicated in a report of the African Commission (cited by Kaufmann, 2005; p.81), *"good governance is the key...unless there are improvements in capacity, accountability, and reducing corruption....other reforms will have only limited impact."* The Zambian health sector is not an exception when it comes to meeting these key criteria. In this regard, during the adoption of the health SWAp, emphasis was placed on the formulation and implementation of robust joint administrative systems in planning and progress reporting, accounting and audit, procurement and technical assistance, so as to enhance transparency

and accountability. This section examines in more detail, the effectiveness of these systems in enhancing transparency and accountability.

5.3.1.1 Financial Accountability

This sub-section specifically assesses the extent to which the health SWAp has enhanced financial management and accountability by looking at the adequacy of the accounting system including disbursement procedures, audit systems, and compliance as reflected by the key informants and document reviews. As a comparator, the section starts by ascertaining the level of financial accountability before the SWAp.

Prior to 1992, management of resources allocated to the district (including procurement and expenditures reporting) was the responsibility of the Provincial Accounting Control Unit (PACU) existent in all provinces at the Provincial Permanent Secretary's office. This arrangement did not make it possible for MoH to properly account for all the resources due to improperly devised financial control systems and procedures. The accounting system in place was manual and in most cases there was low compliance to the budget as certain expenditures were incurred on budget lines where there were no resources. This made it difficult to adequately link budget execution to the annual action plans and the NHSP.

Following the decentralisation of health services, and commencement of basket funding in 1993, the government through MoH started disbursing funds directly to the districts. This development created a need to build district capacity as well as to provide guidelines on the utilisation of these resources. As such, the FAMS was developed and by 1994, it was introduced in nearly all the 72 districts in Zambia (Ministry of Health, 1997a). The FAMS is a tool that was designed to ensure efficiency and transparency in the utilisation of resources through the capturing of information for monitoring and evaluating financial performance of all institutions benefiting from basket funding.

For FAMS to be operational, all districts were equipped with computers and a rigorous and regular programme for training accountants was put in place. In particular, a tailor made financial management course was institutionalized at the Zambia Centre for Accountancy Studies (ZCAS) to cater for in-service training of district accounting cadres. In addition to providing capacity building courses for staff in financial systems and procedures, several planning and management information handbooks have from time to time been developed and disseminated to all health and statutory boards/bodies.

Asked about the effectiveness of the FAMS, many respondents believed that it had greatly improved transparency and financial accountability. The basic understanding among all the respondents was that FAMS relates financing to results and that the FAMS had been greatly

enhanced by the adoption of the MTEF system by government in 2004 (Key Informant Interviews – Box 5.4).

Box 5.4: Key Informants on Financial Accountability

***Bilateral CP**: "Good Activity Based Budgeting (ABB) and accounting system (FAMS) in place. FAMS relates financing to results. GRZ has also adopted ABB through the MTEF which relates financing to the national health policy, NHSP and results".*

***FGD**: "Money goes from CPs to CBoH accounts and is then sent directly to recipient districts and facilities with a disbursement schedule to all recipients. This ensures transparency". For example, at health centres, the disbursement schedules are actually stuck on the notice boards and where there are fluctuations between the amount specified on the schedule and actual money sent, reprimand action is taken.*

***Multilateral CP**: "FAMS embodies most GRZ systems. Most CPs are happy with it though it requires a bit of strengthening. FAMS is a very good system especially at lower levels-districts".*

***Multilateral CP**: "The SWAp has put in place good accounting systems. Management of services was at provincial level but now in all the 72 districts whereby the popular structures help to increase community participation. There is good planning and budgeting at central and district levels".*

***Bilateral CP**: "SWAp has probably helped to curb corruption because it involves the strengthening of systems. Corruption is more difficult to do when there are more robust systems".*

The other feature that the respondents commended (highlighted in Box 5.4 above) was the idea of disbursing money directly to recipient institutions with a disbursement schedule. It was pointed out that this system had lessened the number of transactions (number of institutions handling money) and in turn improved accountability. For example, by sending the monies directly to the districts, accompanied by a disbursement schedule, there are assurances that the monies would reach the intended beneficiaries because the beneficiary institutions can track monies allocated to them. This feature was not there before the SWAp and a lot of money was misappropriated. It is also mentioned that even the non-pooling CPs including GFATM, USAID, Imperial College, UNICEF, World Bank, CIDA, UNDP to mention but a few, also disbursed their monies to MoH which in turn sends these monies to beneficiary institutions. Thus, there is some level of confidence in the accounting system partly due to a transparent financial disbursement mechanism.

In terms of existing mechanisms for releasing funds, all basket funds are released on the basis of progress against action plans and budgets outlined in financial reports. All beneficiaries from the basket are each quarter required to submit income and expenditure reports to CBoH for analysis and consolidation into a basket report which is later submitted to the Health Sector Advisory Committee. This committee holds two meetings in a year (March and September) at which the basket reports are reviewed and funds for the next bi-annual

period are released. The basis of approving monies for the next bi-annual period depends very much on how the respective beneficiary institution had performed in relation to the financial report and annual action plan. This system, according to the interviewees, has been instrumental in improving financial accountability.

As part of the basket reports, the debt and audit summary reports are also provided. The essence of ascertaining the debt position is to strengthen budgetary control through compliance to the cash budgeting system as envisioned by the Zambian government in 1993. Suffice to say that since 1993, the Zambian government has remained committed to a cash budgeting system which means that government transactions cannot occur until actual funding is received As such, I argue that encouraging health institutions to present their debt position in the SWAp is one way of encouraging fiscal discipline which is in line with the general government policy. As such, one can conclude that the health SWAp is committed to stabilization and fiscal discipline as envisioned in a cash budgeting system. However, the only drawback is that monitoring of the debt position by the health sector advisory committee is done quarterly and by then, institutions would have already incurred large amounts of debt.

Internal and external audits play a critical role in maintaining controls on expenditure and checks on compliance to financial management procedures. Both internal and external audits (pre and post) are conducted and the assessments are made on expenditure trends, component analysis and identification of significant deviations from annual work plans. Notably, 67 reports were produced on post audits between the year 2001 and 2004. Regular follow-ups on audit findings were also made leading to a reduction in audit queries from the office of the Auditor General from three (3) in the year 2001 to one (1) in the year 2003. At the time of the research, the respondents reported no outstanding audit queries with the Public Accounts Committee. The only major problem is that only financial audits are conducted while non-financial audits including value for money, forensic and electronic audits are not conducted.

By and large, I take therefore, that adoption of the health SWAp has to a larger extent led to contribute to improved financial management and control. Triangulating evidence was cited from two early studies as shown in Box 5.5.

Box 5.5: Triangulating Evidence on Financial Accountability

"From a technical perspective, corruption is adequately dealt with within the health sector. Working with the framework of a SWAp, means that Sweden and other collaborating partners (CPs) have an overview of all resources including GRZ, to the health sector. This implies that Sweden may be more aware of mismanagement of funds and corruption than would otherwise be the case. Within a SWAp environment corruption can be better dealt with than in a traditional project environment and it is getting increasingly difficult for politicians and public servants to misuse funds, regardless of whether it is GRZ funds or CP funds". ***Kandimaa and Mattsson (2001; p.11)***

"By increasing the share of funding provided to districts and, even more importantly, improving the predictability of resource transfers, the basket made the Government's commitment to decentralization a reality. It also provided the impetus for the development of sound financial management and monitoring systems". ***Frantz et al (2004; p.1-2)***

The primary review and triangulating evidence from earlier authors therefore counteract the commonly held view that SWAps increase the chance of corruption when donor funds go into a basket in view of the fact that governments' scope and control is reduced. In actual fact, pooling can strengthen existing government systems through the implementation of sound financial management controls.

5.3.1.2 Transparency and Accountability in Procurement

The ability of the health system to procure goods and services transparently and accountably is one of the cornerstones of the health SWAp in Zambia. Assessment of the capacity of the current procurement services is a comprehensive undertaking which goes beyond the scope of this paper. This paper looked at the capability of the procurement services in the SWAp as perceived by the key informants. Perceptions on the capacity of the procurement units in the health sector was also made by looking at minutes of SWAp meetings and triangulating evidence from other assessments that have so far been conducted in Zambia.

Responses from the interviews on the adequacy of the MoH procurement services were mixed. Whilst officials from MoH indicated that the current system was adequate, most of the CPs indicated otherwise. The argument from MoH officials was based on the current procurement systems and procedures that came with the adoption of the SWAp. It was stated that a number of procurement units and tender committees had been formulated in all provinces and districts as part of the decentralisation process leading to strengthened transparency and accountability in procurement. The reasoning behind this was that procurement guidelines were disseminated to procurement units and tender committees on an annual basis of which compliance was ascertained through regular monitoring and evaluation visits. At national level, the bone of contention was that in all bulk procurements under the SWAp, CPs were involved in giving a "no objection" before proceeding to the next

stage of procurement i.e. during the closing and opening of tenders, and tender evaluation. Views of the respondents are presented in Box 5.6 below.

Box 5.6: FGD and Key Informants on Transparency and Accountability in Procurement

"There's been tremendous improvement in accountability for procurement. Let's look at it from this angle. The SWAp has come with its own rules. There must be a finance committee, a tender committee and so on. So in terms of transparency, its there. It has really helped in some areas for the Director of Health not to bulldoze the decisions on how the funds should be spent. But of course, there are still pockets here and there, where such practices are still there. In any system, as long as you are dealing with human beings, there is no perfect system that can eliminate these problems 100%". ***FGD***

"The tender committees are very effective and the composition is very wide. All the tender committees are now operating under the Zambia National Tender Board (ZNTB) Act. So, when making a major procurement the committee has to sit. The head of the institution has to be there, the departmental heads and members from the community (who are act as 'whistle blowers') also have to be there. If members of the community are not happy and even though they are shy in that meeting, immediately they come out some of them immediately go to the Anti-Corruption Commission (ACC). They report to ACC citing cases of malpractices with the minutes of the previous tender committee meeting in their hands. ACC will then go to the particular district and investigate". ***FGD***

"The records of proceedings in all the tender committee meetings are actually there and one is able to go there and read". ***FGD***

Multilateral CP*: "SWAp has general improved accountability. However, SWAp has not completely solved issues around procurement but improving".*

Bilateral CP*: "Buying committees and tender committees at lower levels are involved in procurements in line with the Zambia National Tender Board (ZNTB) act. Large procurements requiring higher thresholds are done at the next level. Competence in procurement is good but more needs to be done".*

However, a review of the minutes of the Implementation Review Steering Committee (IRSC) as well as the Health Sector Committee (HSC) clearly revealed that the MoH procurement unit lacked the necessary capacity to undertake bulk procurements. For example, GFATM had opted to use the UNICEF procurement systems in the procurement of ARVs due to inadequate capacity in MoH. Importantly, the MoH procurement system was considered to be lengthy and that they didn't make use of framework contracting. The other key issue was that the health sector had been operating without a procurement plan until 2005 when the first plan was developed.

As part of efforts to improve the capacity of procurement in the SWAp, MoH and its CPs engaged the World Bank to undertake a thorough assessment of the capacity of MoH to procure for the entire health sector. In general, the assessment indicated an average risk rating and a summary of the results are presented in Table 7 below.

Table 7: Procurement Risk Rating

Procurement Aspect	Target Score	Actual Score	Weight
Legal Status	1	0.5	4
Procurement Cycle Management	1	0.5	4
Quality of Procurement Plan and Past Performance against Plan	1	0	4
Support and Control Systems	1	0.5	4
Record Keeping	1	0	4
Staffing	1	1	4
General Procurement Environment	1	0.5	4
Private Sector Assessment	1	1	4
Total	**8**	**4**	**4**

Source: Ministry of Health, 2005d

Score
0 - No Progress
0.5 - Partially Achieved
1 - Fully Achieved

Weighting
1 - Least Important
2 - Very Important
3 - Very Important
4 - Essential: Must be achieved

5.3.1.3 Accountability for Performance

One of the consequences of adopting a health SWAp has been the measurement of the impact of investments in terms of the overall health sector performance as opposed to narrowly defined and easily measurable project type outcomes and outputs. As such, MoH and its CPs had to review the Health Management Information System (HMIS) in 1996 in order to make it results oriented and responsive to the local decision making process. This was after the realisation that the system that was in place was excessively centralized, fragmented, and resulted in the collection of large amounts of data, which was not useful for local decision-making. Thus, the current HMIS should make it possible to monitor the performance of the health sector performance in terms of the impact of health services delivery on disease incidence, availability of drugs and other medical supplies.

In terms of sufficiency of the HMIS as a tool for monitoring and evaluation, various issues and concerns were raised by the key informants. The argument was that the HMIS was not results oriented and that the quality of the data that was being collected was poor. It was felt that the current HMIS indicators do not provide a good judgement of the level of performance, level of effort and that they were not aligned to the Millennium Development Goals (MDGs). The other issue was that was very minimal analysis of the HMIS indicators during the SWAp consultative meetings. These sentiments augment earlier comments that were raised during the Health Sector Committee meeting of 29th April 2004. At that meeting, it was resolved that MoH should make significant steps to improve performance assessment in the health sector after a general consensus over the inadequacy of the same.

In addition to the above, an institutional and organisational appraisal of the health sector that was conducted in June 2004 also pointed to the lack of a performance management system in the health sector which made it difficult to account for performance and to achieve set targets. Key informants were very emphatic on this issue as reflected in Box 5.7.

Box 5.7: Key Informants on Accountability for Performance in the SWAp

***Bilateral CP 1**: "Although national systems are used and have been strengthened, a lot of reporting is done to satisfy the CPs. At SWAp meetings, the idea is to check if all beneficiaries from the basket have reported accordingly. It's more about the cover and not the content. The whole sector is not ideally performance oriented and there are very little incentives within the system to actually provide the results. Incredible data is produced and information available is good both financial and progress. But the move to improve performance is limited".*

***Bilateral CP 2**: "Provincial assessments have tried to reinforce the need to make the system more performance focused but they are not doing much. Far and beyond the sector is not performance oriented at all. Need to define performance and scores to be given on certain performance achieved. This will at least help the sector to get away from reporting for the sake of reporting to reporting for the sake of performance".*

***Bilateral CP3**: "Districts are not really funding all the planned activities. Some CPs argue that yes MoH does its part by disbursing the money directly to districts but what the district managers do with the money when it reaches them leaves a lot to be desired. As a result there is no impact".*

***MoH Official**: "There is a need to improve accountability for performance and HMIS indicators".*

***Multilateral CP**: "Weak M&E. HMIS is good but the indicators don't provide the necessary comparisons. Also not disaggregated by age, socioeconomic status and gender".*

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5.3.2 EFFICIENT USE OF RESOURCES

5.3.2.1 Administrative Efficiency

5.3.2.1a Time Spent in Meetings as an Indicator of High Transaction Costs

It was observed that a considerable amount of time is spent attending SWAp coordination meetings in the Zambian health SWAp. This is as a result of there being numerous meetings to attend to in a week, in a month and subsequently in a year. This includes the Monitoring and Evaluation committee meetings which are held every Wednesday; not less than two Technical Working Group meetings each week; a Policy Consultative meeting every month; two Health Sector Advisory committee meetings every six months; one Annual Consultative meeting; and one Heads' of Missions meeting every year. This puts the cumulative number of meetings at 3 in a week; 13 in a month; and 160 in a year. Members of staff also attend other separate technical meetings that are organized by multilateral CPs (UNICEF and WHO), bilateral CPs (USAID) and global health initiatives (GFATM). On top of this, key MoH staff also attend other government meetings more especially at the Ministry of Finance and National Planning on a regular basis.

On the other hand, the SWAp meetings are so comprehensive that staff from the SWAp secretariat and other key MoH officials spend a lot of time organizing these meetings. Action points that are raised in each meeting have to be adequately followed up before the next meeting and this consumes a lot of time.

From the above, it is apparent that transaction costs are still very high in the SWAp owing to the number of meetings as well as their comprehensiveness. This is despite the streamlining of SWAp meetings in 2004 (Minutes of the February 2004 Policy Consultative meeting) and the conviction by some of the key informants that the CPs were gradually distancing themselves from implementation issues.

5.3.2.1b Number of CPs Using Separate Systems as an Indicator of High Transaction Costs

Though the number of CPs fully participating in SWAp meetings is reasonably high (15 in total), a good number of these CPs have their own separate planning, budgeting and reporting formats. GFATM and PEPFAR are some examples of CPs using separate systems. Additionally, some of the bilateral CPs also run parallel projects despite pooling resources. The effect of these types of management arrangements on outstripping staff time cannot be overemphasized. Whilst frequent and regular meetings directly affect staff based at MoH headquarters, staff based at lower levels are deeply affected by the separate reporting formats. The Provincial Financial and Data Management Specialists were resounding on this issue as illustrated in Box 5.8.

Box 5.8: FGD on High Transaction Costs in the Zambian Health SWAp

During a FGD with Provincial Financial and Data Management Specialists over the existence and effect of separate reporting formats, the following was expressed.

"The SWAp has failed us. The objective of a SWAp is to come up with a common report which will be accepted by all the players in the SWAp. If I submit one financial report it should be able to meet the needs of everyone. But what is happening now is that the World Bank sends the money, Global Fund sends the money, and WHO sends the money. I have submitted my financial report which encompasses all these funds and I have explained how they were spent. Again, I get another letter saying that I should submit another report to satisfy one CP. Then it defeats the purpose of the SWAp because one report is supposed to answer questions for all these players. Ironically, the instructions to submit extra reports come from CBoH".

"When we are reporting we do not feel aligned more to the SWAp but we report with the same impetus to vertical programmes as well. The complication is that if I don't submit reports to all the funders; the letters that come, they come with threats – if you don't do this by that day then your districts will never get any money from this particular CP. But I mean we have the interest at heart of all the districts and hospitals in the province. So we report in the particular format that the particular CP wants for us to continue benefiting. This is because if we lose that particular resource it wouldn't auger well to the districts and hospitals in my province. So the same way I will pay attention to the SWAp report is the same way I will pay attention to this other report being asked for by this other CP. This is time constraining".

"Once you agree that people put money in the basket and agree to a set of rules and a format of the report. We should stick to that. We don't want to start seeing some more requests for reports in different formats. That's now not sticking to the SWAp guidelines. So, we need to work on this one. We don't want again to start submitting individual reports to particular CPs within the same SWAp. It's defeating the whole purpose. People are being tossed here and there."

"Apart from the SWAp we do have a lot of smaller NGOs sponsored by USAID whose reports we have to consolidate at provincial level".

In order to augment the comments from the FGD, it is worth mentioning that there are over 15 multilateral and bilateral projects working on HIV/AIDS in Zambia at the moment. All these projects have their own implementation and reporting formats even though some of them buy into the overall National HIV/AIDS strategic plan. This suggests high transaction costs and duplication of activities. For example, by the end of 2004, USAID alone was operating over 24 sub-projects on HIV/AIDS which were operational in 128 sites in 40 districts covering 8 provinces. On the other hand, the World Bank approved a grant of $42 million to support HIV/AIDS activities for a period of 5 years commencing in July 2003 under the Zambia National Response to HIV/AIDS (ZANARA) project. The ZANARA project covers 4 components including the Community Response to HIV/AIDS (CRAIDS), National AIDS Council, all line ministries and a Programme Administrative Unit (PAU) at the Ministry of Finance and National Planning (MoFNP). By the end of 2004, ZANARA was funding 73 sub-projects in all the 9 provinces under the CRAIDS component. Regrettably, the ZANARA

funds are not managed by MoH but MoFNP through the PAU. This has made it difficult to integrate the ZANARA activities within the SWAp and as such, the project does not complement other HIV/AIDS programmes in the health sector.

Analysis of the number of projects which were operational before the adoption of the health SWAp in 1993 showed that there were about 59 multilateral and bilateral projects covering a wide range of public health interventions and not only HIV/AIDS. This to some extent can be attributed to the HIV/AIDS pandemic whose programmes/activities are being supported by a number of CPs the world over. The general observation that can be made from the above is that the SWAp mechanism as a whole has not promoted administrative efficiency as transaction costs are still high and that there is a lot of duplication of activities (more so on HIV/AIDS) due to the use of separate funding and implementation systems.

5.3.2.2 Technical Efficiency

5.3.2.2a Hospital Bed Occupancy Rate as an indicator of Technical Efficiency

The hospital bed occupancy rate is one of the indicators that the MoH uses to assess the efficiency (in terms of productivity) of district hospitals. The purpose of the indicator is to ascertain the utilization of district hospitals for inpatient treatment and the national annual target is 80% bed occupancy. The data in Table 8 below reveals that on average the national bed occupancy rate between the period 2001 and 2005 was 50%, with the worst figures found in Southern, Western and Copperbelt provinces. Before the introduction of the SWAp in 1991, available data indicate that the national bed occupancy rate was 71.2% (Ministry of Health, 1992). This means that during the last four years of the SWAp, district hospitals were being under utilised and this could be due to either poor quality services (equipment, patient beds, food etc) and/or lack of core staff (nurses and doctors). This line of argument was explored and most of the key informants revealed that the productivity of the district hospitals had dropped as a result of inadequate human resources and drugs.

Table 8: Hospital Bed Occupancy Rate 1991-2004

Province	1991	2001	2002	2003	2004	Average (2001-2004)
Central	-	65	32	64	59	55
Copperbelt	-	45	27	58	50	45
Eastern	-	81	55	57	59	63
Luapula	-	72	64	58	56	63
Lusaka	-	34	61	66	72	58
Northern	-	65	54	62	53	59
North/Western	-	58	60	55	54	57
Southern	-	41	51	48	47	47
Western	-	56	40	40	45	45
ZAMBIA	**71.2**	**54**	**40**	**55**	**52**	**50**

Data Sources: Ministry of Health (1992); CBoH (2005)

5.3.2.2b Health Centre Staff Daily Contacts as an indicator of Technical Efficiency

The health centre staff daily contact rate measures the average number of daily contacts for each qualified health worker in a health centre over a reporting period (year). It is calculated by dividing the total number of contacts during that period with the number of available qualified staff-days (8 hours per day for 6 days). The recommended staff workload is 15 contacts per staff per day and if this number is higher, it means that there is low staffing and this may affect the quality of health care provided.

Table 9 below, assesses the national average daily health centre staff contact rates during the SWAp implementation period 2001 to 2004 and the indication is that the figures had been rising. The national average daily client-staff contacts was 14.4 in 2001, 15.9 in 2002, 17.1 in 2003 and 17.2 in 2004. The results are not affected by differences in utilization rates that could account for differences in workloads in health workers in rural and urban areas given that the users in urban areas have access to other service providers. This is because there was a general under utilization of health centres during the period 2001 to 2004 in both the rural and urban areas (CBoH, 2005).

Table 9: Health Centre Staff Daily Contacts: Zambia 2001-2004

Province	2001	2002	2003	2004	Average
Lusaka	13.7	13.1	14.3	14.9	14.0
Copperbelt	9.6	10.7	10.7	11.9	10.7
Central	14.2	15.8	15.6	22.5	17.0
Southern	12.8	14.3	15.6	15.7	14.5
Eastern	15.8	25.4	28.1	26.2	23.8
Luapula	23.3	25.4	25.6	27.4	25.4
Northern	20.8	20.2	23.9	18.9	20.9
North Western	20.6	21.8	24.0	22.6	22.2
Western	22.7	21.2	23.5	23.4	22.6
Zambia	**14.4**	**15.9**	**17.1**	**17.2**	**16.1**

Data Sources: Central Board of Health (2005)

This above reflects inadequate staffing in health centres especially in rural areas. This is because a breakdown of the health centre staff contacts by provinces shows that rural provinces (Eastern, Luapula, Northern, North-Western and Western) recorded the highest workloads of above 20 in most cases, between 2001 and 2004. For example, in 2004, 71% of all the districts recorded workloads above the target of 15 out of which 80% of these districts were rural. On the other hand, urban provinces like Central and Copperbelt had continually lower daily client contacts between 2002 and 2004 in that they are better staffed.

The implication of these results is that though the SWAp has placed emphasis on the districts, evidence suggests that there has been inadequate support for human resources during the SWAp implementation period 2001 to 2004 leading to an inequitable distribution of

human resources. Thus, though the 2005 CBoH HMIS report shows that there was general under utilization of health centres in the country, the available health workers were inadequate to serve all the users. This has implications on the quality services of services provided especially in rural health centres.

5.3.2.2c Trends in funding drugs as an indicator of Technical Efficiency

Expenditure on drugs is one of the major cost drivers in most health system and the availability of essential drugs is considered to be a proxy indicator for the quality of health care provided. Henceforth, allocating sufficient monies towards the procurement of quality and affordable drugs ought to show how committed GRZ and its CPs are to providing quality health care. Table 10 shows the budgetary allocations for drugs as a percentage of the total health budget (GRZ & CPs) for the period 1990 to 2005.

Table 10: Budgetary Allocations for Essential Drugs 1990 – 2005

	1990-1992 $USD	1995-1998 $USD	2004 $USD	2005 $USD
Total Health Budget	29,836,121.02	108,090,062.76	149,982,590.24	197,993,978.32
GRZ Budget on Drugs	6,280,735.66	7,066,610.75	4,581,539.98	5,387,178.04
CPs Budget on Drugs	-	10,876,339.67	4,774,557.34	22,547,086.44
GRZ Budget on Drugs as %age of Total Health Budget	21.1%	6.5%	3.1%	2.7%
CPs Budget on Drugs as %age of Total Health Budget	-	10.1%	3.2%	11.4%
Combined GRZ & CPs Budget on Drugs as %age of Total Health Budget	-	16.6%	6.2%	14.1%
Estimated Annual Requirement for Essential Drugs (excludes Vaccines, ARVs, Malaria drugs)	-	-	**21,000,000.00**	**21,000,000.00**
Estimated Drug Requirement as %age of Total Health Budget	-	-	14%	11%
GRZ Budget on Drugs as %age of estimated Drug Requirement	-	-	22%	26%
CPs budget on Drugs as %age of estimated Drug Requirement	-	-	23%	107%
Unfunded Balance	-	-	**55%**	**-33%**

Data Sources: CBoH Basket Reports, 2005; Daura & Mulikelela,1998; GRZ Estimates of Revenue and Expenditure 1991; 1993; 1996; 1997; 1999; 2005; 2006; Ministry of Health 2001; 2003

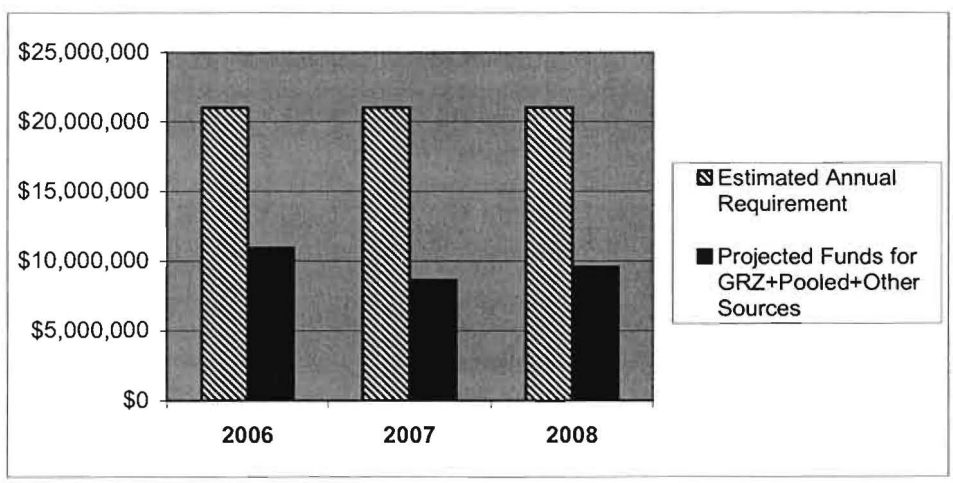
The above results show that the GRZ drug budget as a percentage of the total health budget averaged 21.1% between the period 1990 to 1992 (pre SWAp) but dropped to 6.5% between 1995 and 1998 (post SWAp) and then to 2.7% in 2005. While data for drug financing by CPs

before the SWAp (1993) was not available, the combined GRZ and CPs drug budget as a percentage of the total health budget dropped from 16.6% over the period 1995 to 1998 to 6.2% in 2004 and then increased to 14.1% in 2005.

The above results suggest that funding for drugs has reduced during the SWAp implementation period 1993 to 2005, specifically the GRZ allocation. Comparison of the budgetary allocations for drugs to the estimated annual requirement for essential drugs also shows that funding for drugs has not been sufficiently prioritized during the SWAp era. It has been estimated that the Zambian public health system requires $21 million per year in order to satisfactorily procure all the essential drugs (Ministry of Health, 2001; Ministry of Health, 2003). However, as shown in the shaded region of Table 10, GRZ and its CPs were expected to allocate about 14% of the total health budget on drugs in 2004 but only allocated 6.2%. In 2005, however, GRZ and its CPs were expected to allocate 11% for drugs but the actual allocation was 14.1%. This is mainly attributed to the sourcing of more money to cater for the procurement of ARVs, anti-malarial drugs and vaccines from the global health initiatives. This money, though reflected in the total annual health budget, is not part of the annual drug estimate of $ US 21 million.

The general implication of the above results is that drug financing has not been adequately prioritized, especially by GRZ. Interviewees actually noted that insufficient budgetary allocations for drug have led to rampant drug shortages in most health facilities. A look at the MTEF projections for 2006 to 2008 as illustrated in Figure 7 further illustrates the inadequate budgetary allocations for drugs.

Figure 7: Drug financing all sources: Zambia 2006 - 2008



Data Source: Ministry of Health, Planning Department

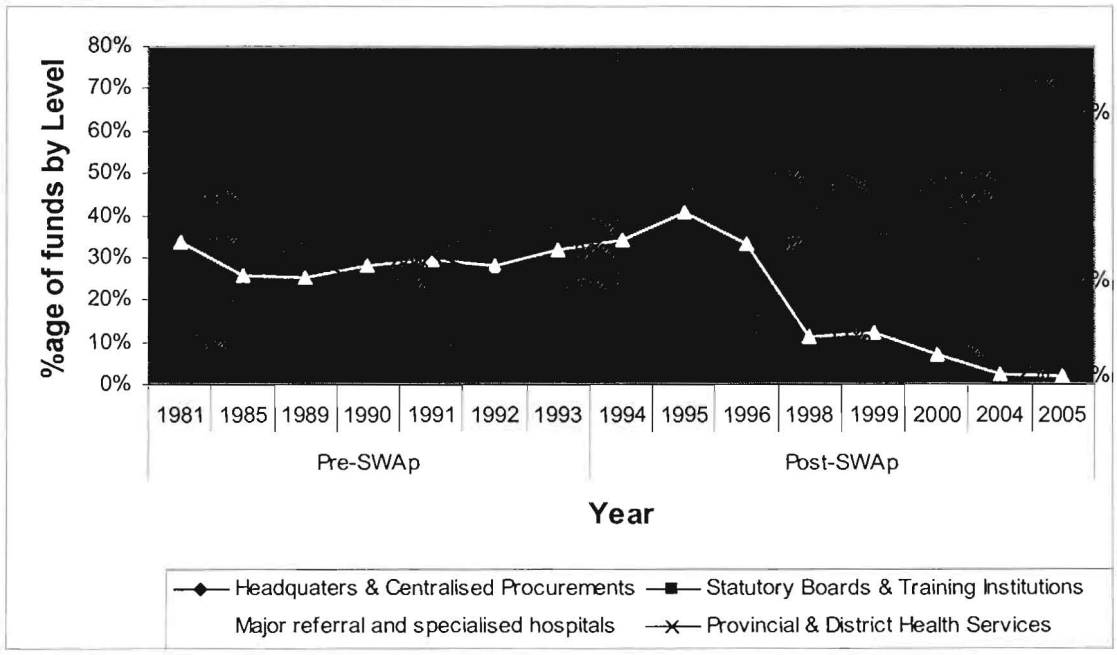
5.3.2.3 Allocative Efficiency

5.3.2.3a Budgetary Allocation of Funds by level of Health Care as an indicator of Allocative Efficiency

According to the SWAp guidelines on the distribution of funds by level of health care (MoH, 1999; MoH, 2000b), a minimum of 60% of the total resources coming from GRZ and CPs are supposed to be allocated to district health services; 20% to major referral and specialised hospitals, 10% to MoH headquarters and the remaining 10% to Statutory boards/Training Institutions. Figure 8 below explores the extent to which MoH has achieved this milestone, by looking at the budget allocation between 1981 and 2005. Unfortunately, it was not possible to obtain isolated figures for district health services as available data tied the budgetary allocations to provinces. This was also the case for MoH headquarters whose allocations were tied to centralized procurements.

The results show that GRZ has been fairing well in terms of budgetary allocations to provinces and districts. In the early 1990s (pre SWAp), less than 40% of the budgeted amounts were for provincial and district health services as compared to 2004 and 2005 when 71% and 64% of the budgeted amounts were for provincial and district health services, respectively. It should also be noted that these figures do not include personnel emoluments and bulk procurement of drugs as these expenses are incurred at central level. Conversely, it appears that the budgetary allocations for major referral and specialised hospitals have been declining (from 34% in 1981 to 2% in 2005) while the allocations for MoH headquarters and centralized procurements increased from 9% in 1981 to 24% in 2005.

Figure 8: GRZ Budgetary allocations by level of Health Care: Zambia 1981-2005

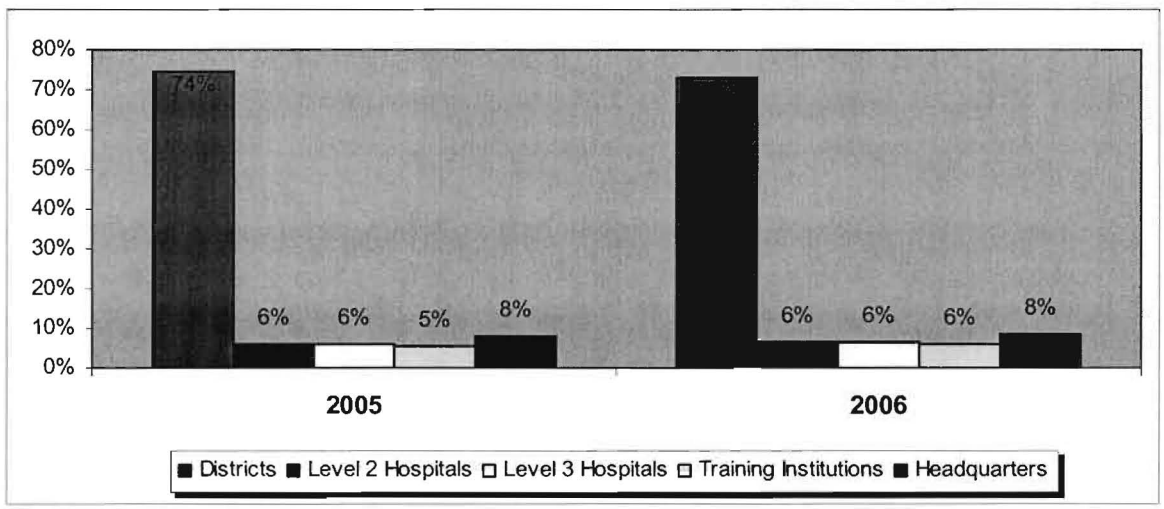


Data Sources: Ministry of Health (1992); Ministry of Health (1994); Ministry of Health (1998); Ministry of Health (2000a); CBoH Basket Reports (2003-2005)

Figure 8 also highlights the focus of the SWAp on increased budgetary allocations to the districts as evidenced by the large variations in centralised procurements and headquarters between 1994 and 1998. The underlying reason is that between the period 1994 to 1998 when the SWAp was still in its infancy, the Zambian government was allocating more monies to the districts in order to demonstrate its commitment to the SWAp, particularly increased district level funding. This led to reduced allocations for centralised procurements and headquarters. However, after 1996 when the CBoH become operational, more allocations were made to centralised procurements and headquarters at the expense of major referral and specialist hospitals.

Analysis of CPs budgetary allocations to different levels of the health sector during the SWAp era (2005 – 2006) also show that there is a shift towards more district funding as compared to the other levels of the Zambian health care delivery system. Whilst it was not possible to determine CPs budgetary allocations to the districts before the SWAp, Figure 9 below, presents the budgeted figures for 2005 and 2006 which only includes CPs contributions to the basket. The indication is that over 70% of the funds from the basket were budgeted for the districts while all the other levels were allocated less than 30%.

Figure 9: CPs Basket Funds allocation by level of Health Care: Zambia 2005 and 2006



Data Source: CBoH Basket Reports, 2005

From the foregoing, it is sufficient to conclude that the budgetary allocations are in line GRZ's vision of having more resources at the district level. Apart from GRZ and CPs' basket funds, it is worth noting that the districts also receive substantial amounts of money from global health initiatives and multilateral/bilateral CPs through disease-specific vertical programmes. However, even though government's intention is for districts to receive the bulk of the financial resources and that this is indeed indicative of a pro-poor approach, the budgetary allocations are not in line with the agreed minimum SWAp guidelines on the distribution of funds by level of health care (outlined in the first paragraph of sub-section 5.3.2.3a). As a

result of this, the health system fails to adequately provide quality health care especially in specialist hospitals which are supposed to treat complicated referral cases from the lower levels. The stopgap measure that is employed by most specialist hospitals is to increase the amount of user fees in order to generate more resources to be able to provide some of the essential services. However, this subjects consumers to increased burden in terms of financing their health care leading to reduced access and impoverishing effects of illnesses.

5.3.2.3b Budget Performance and Timing of disbursements

Notwithstanding the importance of assessing the budgeted amounts by level of health care, it is also important to find out if the full allocations are disbursed to beneficiary institutions at the right time. This is because programme managers at district and other levels of the health care delivery system need regular and predictable funding to be able to work well. Henceforth, even if one shows that there is enough money in a year, which is released according to the budget, the money cannot be used effectively if it is irregularly disbursed.

GRZ Commitment to the Budget

Table 11 shows the performance of GRZ towards making releases to the basket as budgeted during the period 1999 and 2005. The analysis excludes monies that GRZ disburses for personal emoluments, centralised procurements and capital projects as these are not disbursed through the basket. The results show that only 20% of the funds that had been disbursed to CBoH for onward disbursement to districts had reached the districts in 1999. In 2003, the MoH had disbursed 88% of the total budgeted basket funds to CBoH but only 19% of these monies were eventually disbursed to the districts. Conversely, 288% and 118% of the budgeted amounts had been disbursed to statutory boards (including CBoH headquarters) and tertiary hospitals in 2003, respectively. The implication of these results is that the CBoH was not making the disbursements in line with the budgets, especially for district health services which are the main focus of the Zambian health SWAp.

Table 11: Budgeted Vs Actual Releases to Basket GRZ Funds ($ USD)

Level of Health Care	Disbursed as %age of Annual Budget		
	1999	2002	2003
Total Disbursed by MoH to CBoH		61%	88%
Total Disbursed by CBoH to Districts	20%	44%	19%
Total Disbursed by CBoH to Statutory Boards (incl CBoH)		117%	288%
Total Disbursed by CBoH to Tertiary Hospitals		70%	118%
Total Disbursed by CBoH to 2nd Level Hospitals		51%	89%

Data Source: CBoH Accounts 1997-2005

A closer examination of the above phenomenon through a FGD revealed that GRZ funding that was being received was far less than what had been approved by GRZ for each year.

On the other hand, it was pointed out that CPs' basket funds were being disbursed regularly and that these funds were close to the budget. This suggests that CBoH was misappropriating GRZ funds while on the other hand committing itself to disbursing the full CPs' basket funding. This trend must have been in existence for a considerable period of time as the financial specialists indicated that for over 4 years prior to the research, GRZ funds were usually received in June and December. The increasing high expenditure at the centre and other related issues, prompted MoH to abolish CBoH in April 2006. The intention was to reduce expenditures at the centre and to reallocate the savings to the periphery.

The above results can be linked to the results in sub-section 5.3.2.3a where it was established that GRZ budgetary allocations were not in line with the MoH guidelines on the distribution of funds by level of health care. Due to the unrealistic budgetary allocations, it must have been difficult for CBoH to effectively release monies according to the budget. As such, it is possible that less money was being disbursed to the districts in order to commit the savings to hospitals and other levels that were under budgeted. This confirms Lake and Musumali's (1999) observation that focus on one level of the health system could actually lead to inefficient intra-sectoral resource allocation decisions.

CPs Commitment to the Budget

Tables 12 and 13 show CPs' commitment to budgets between 1990 and 2005. Table 12 includes all programmes and projects that were being run in the health sector while Table 13 only includes basket funds. The results in Table 12 show that between 1990 and 1992 (before SWAp) the CPs had actually released close to 90% of the budgeted amounts and 83% of the budgeted amounts between 1995 and 1999 (after the SWAp). Table 13, on the other hand shows actual releases to the basket as a percentage of budgeted amounts by some of the major basket funders between 1999 and 2005. Apart from SIDA that had on average released 81% of the budgeted amounts, most of the CPs had released more than what they had budgeted for between the review period.

Table 12: Budgeted Vs Actual Releases CPs (Basket and Other Funds $ USD)

	Year	Annual Budget	Disbursed	Disbursed as %age of Annual Budget
Pre-SWAp	1990	13,000,000.00	13,600,000.00	105%
	1991	13,400,000.00	11,900,000.00	89%
	1992	15,700,000.00	12,600,000.00	80%
	Total 1990-1992	**42,100,000.00**	**38,100,000.00**	**90%**
Post-SWAp	1995	46,063,000	33,163,000	72%
	1996	44,736,000	42,199,000	94%
	1997	64,463,000	49,205,000	76%
	1998	53,611,000	30,322,000	57%
	1999	35,902,000	41,297,000	115%
	Total 1995-1999	**244,775,000**	**196,186,000**	**83%**

Data Sources: Mtonga (n.d); Daura & Mulikelela (1998); Ministry of Health (2006b)

Table 13: Disbursements to the Basket as a Percentage of Budgeted - Major CPs

	CP	Year			
		1999	2003	2005	Average for Period
1.	SIDA	66%	92%	84%	81%
2.	EU	126%	114%	100%	113%
3.	DANIDA	0%	131% (incl. DCI)	71%	-
4.	DGIS (RNE)	116%	201%	92%	136%
5.	DFID	-	210%	161%	186%
6.	DCI (IRELAND AID)	93%		101%	
7.	UNFPA	-	33%	204%	119%
8.	USAID (SPA)	-	33%	214%	124%

Data Source: CBoH Accounts 1997-2005

The implication of the above is that the CPs (all sources) were releasing less than the budgeted amounts after the SWAp than before the SWAp (Table 12). However, if one looks at the releases to the basket (Table 13), there were fewer negative variations in budgeted amounts against the actual releases. This suggests that CPs that are pooling resources were more committed to the health sector than those running vertical programmes and projects. Put differently, this reveals that funding to the basket was more predictable than funding for vertical programmes.

In terms of regularity of releases to the basket, the CPs had 3 options of releasing monies i.e. quarterly, biannually or annually. Some CPs like DGIS released their monies biannually based on a balancing claim arrangement. Asked if the monies were released on time from the CPs' coffers to the basket accounts at MoH, the Financial Specialists based at headquarters were affirmative. The same question was posed to Provincial Financial Specialists and the idea was to find out if CPs' basket funds were released on time from the basket accounts at MoH to the beneficiary institutions' accounts. Again, the answer was positive. It was however, difficult to ascertain if the funds were timely released from the beneficiary institutions' (districts, hospitals, etc) accounts to health centres and health posts for programme implementation.

5.3.2.3c Basic Health Care Package (BHCP)

Given a climate of limited resources, one of the most promising measures that are employed to identify key priority interventions that should be provided at each level of health care at least cost is what is known as packaging. During the SWAp implementation period, MoH has made significant progress in costing the BHCP and by 2001, the costed BHCP for primary and second level services amounted to **US$11.69** per capita to cover primary level care (US$8.33); secondary level care (US$1.12); preventive and promotive care (US$2.12); and District Health Office costs (US$O.12). However, a close evaluation of the available resources through the public sector resource envelope between 2001 and 2005 only

averaged **US$10.1** per capita. It is also important to note that the cost of the BHCP excludes the cost of tertiary care and other top-level referral services such as the cost of new interventions that have been prescribed. This includes the provision of Coartem as the first line treatment for malaria; re-introduction of residual indoor spraying for malaria; provision of extensive voluntary counseling and testing (VCT); provision of free ART (including PMTCT); TB prophylaxis for HIV+ patients; and the introduction of new vaccines such as DPT+ Hib. The abolition of user fees in all districts in April 2006 also means that more money should be provided to cover for the lost revenues.

From the above, it is clear that the Zambian health sector is still short of the required amount of resources for it to adequately provide quality health care to all its people.

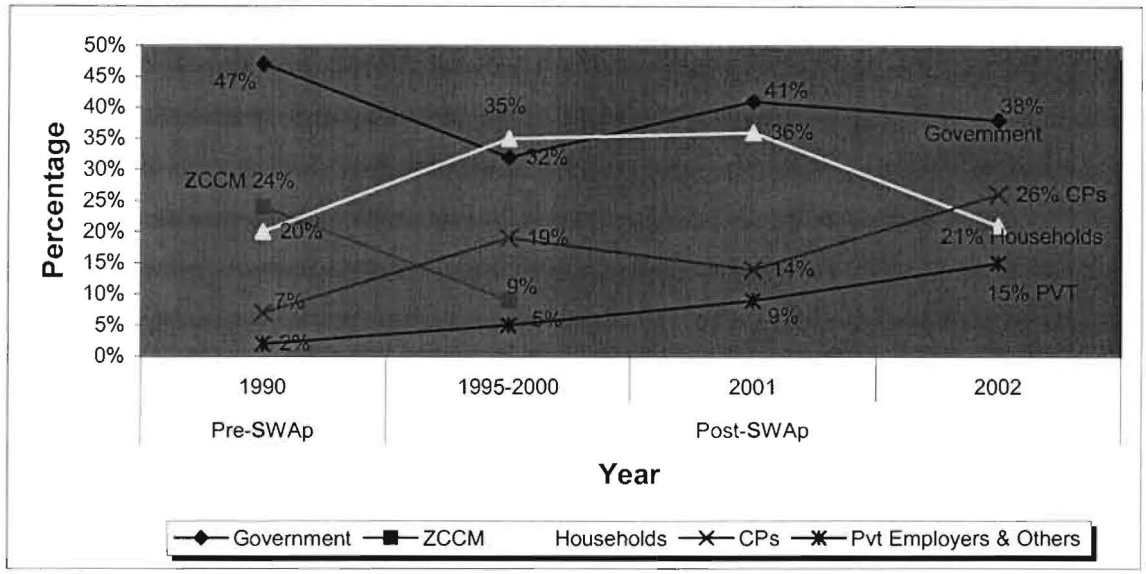
5.3.3 FINANCIAL SUSTAINABILITY

Assessment of financial sustainability in a health system is vital in order for one to ascertain the long term growth of domestic resources over external resources and further, the long-term stability of a mix of health care financing sources. Thus, this section will look at the growth of resources before and after the adoption of the health SWAp. The key caveats will be variations and stability in funding.

5.3.3.1 Growth rate of Health Care Financing from all sources

Figure 10 below shows the main sources of health care financing in Zambia from 1990 to 2002. Here, GRZ contribution includes all the monies that are directed to the health sector through MoH (basket, personal emoluments, centralised procurements, capital projects etc) and other line ministries. The diagram shows that the contribution of GRZ to the Total Health Expenditure (THE) declined from 47% in 1990 (before the SWAp) to 38% in 2002, nine years after the adoption of the health SWAp. On the other hand, the contributions by CPs to THE had increased from 7% in 1990 (before SWAp) to 26% in 2002 (after SWAp) while the contribution of private employers/others (PVT) had also increased from 2% in 1990 to 15% in 2002. The contribution by households had been stable around 20% in 1990 as compared to 2002 but between 1995 and 2000 the households were the largest contributors.

Figure 10: Sources of Health Care Financing: Zambia 1990 - 2002



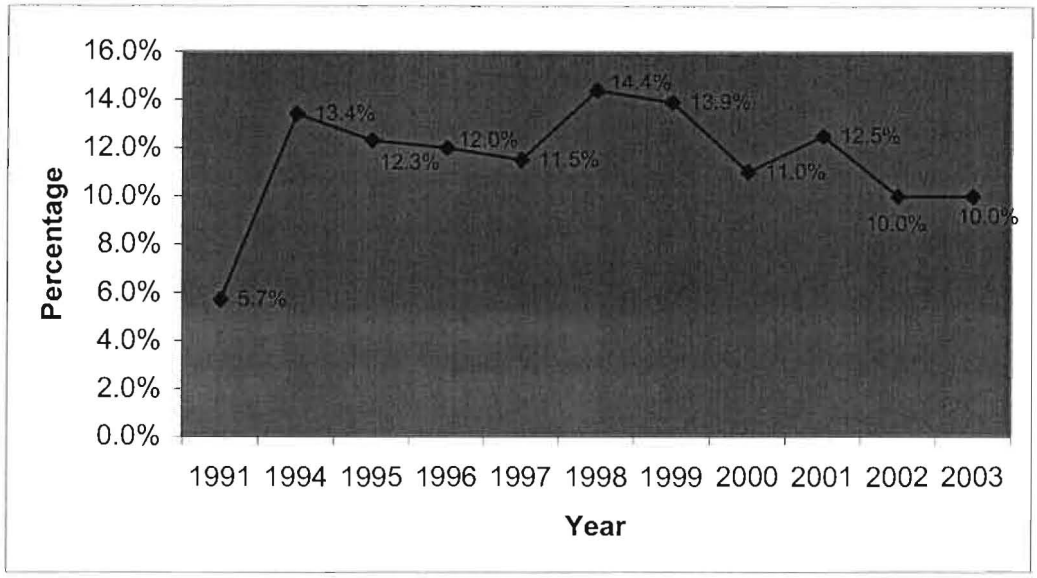
Data Sources: MoH (1992); MoH (1994); MoH (1998); MoH NHA Accounts 1998-2003

The implication of the above is that the private sector and the CPs ventured more into the financing of the health sector after the implementation of the SWAp than before. GRZ's contribution to THE was, however, the highest between 1990 and 2002 if compared to the contributions from the CPs and private employers/others. The added role of CPs could be explained by the increased support through the SWAp and other vertical programmes. For example, a lot of support is being channelled to Zambia by global health initiatives in an attempt to assist Zambia override its huge disease burden due to HIV/AIDS and its opportunistic infections. Another possibility is that Zambia is attracting a lot of external support from several bilateral, multilateral and global health initiatives due to the good systems that the government has put in place through the health SWAp.

5.3.3.2 GRZ Expenditure on Health as % of Total GRZ Discretionary Budget

In most instances, examining government's contribution to the health sector by using THE blurs the actual amount of resources that the government has at its disposal and what it actually spends on health through the public health system. For this reason, the above assessment is made in Figure 11. The results show that government had increased its expenditure on health from 5.7% in 1991 (before SWAp) to 13.4% (when it started contributing resources to the district basket in 1994) but by the end of 2003, GRZ was only spending 10% of its budget on health.

Figure 11: GRZ Expenditure on Health as % Total GRZ Discretionary Budget Zambia 1991-2003



Data Sources: MoH (1992); MoH (1994); MoH (1998); MoH NHA Accounts 1998-2003

The figures throughout the review period are however, below 15%. This means that the Zambian government has not adequately prioritized health in accordance with the requirements of the Abuja declaration which calls for African governments to spend 15% of their discretionary budget on health. This is despite Zambia having a huge disease burden mainly due to Malaria, HIV/AIDS and its opportunistic infections.

To understand the commitment/sustainability of government financing during the SWAp, one has to look at the period 1997-1999 when there were partnership problems in the SWAp whereby some CPs had withheld funding to the sector as explained in sub-section 5.2.1.1. The salient feature is that GRZ responded by increasing its expenditure on health from 11.5% in 1997 to 14.4% in 1998 and then 13.9% in 1999. This to some extent shows that GRZ was committed to the health sector and that it actually owns the SWAp process. This suggest that GRZ can take up the responsibility of funding all programmes in the health sector if the CPs were to pull out though the level of sustenance (in terms of the scale and actual programmes taken over, level of financing, and longevity) could not be adequately gauged.

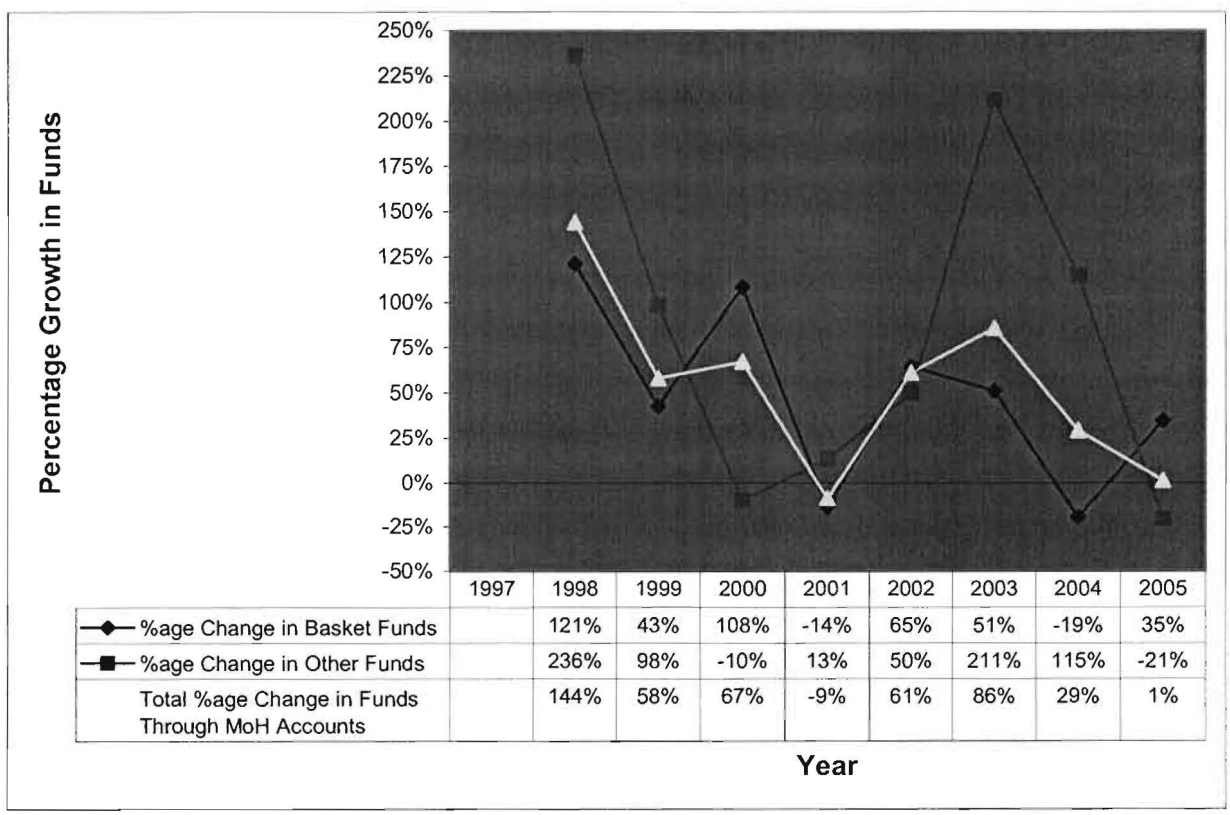
However, with renewed partnerships and commitments by CPs, the government reduced its allocation from 14.4% in 1998 to 10% in 2003. The above is a classic case of fungibility in that GRZ re-prioritized the allocation of funding to line ministries with MoH which is regarded to be donor-congested progressively getting less money as compared to other social sectors. CPs have pointed out the inadequate commitment of GRZ to the health sector and one such occasion was during the 2004 Annual Consultative Meeting where it was observed that the GRZ contribution to the health sector was declining, both in nominal and real terms, as the CPs share went up. As a result, unlike other Annual Consultative Meetings held with CPs

where the pledges for the coming year are renewed, the meeting decided not to renew the pledges for 2005 until the GRZ contribution was slightly increased.

5.3.3.3 Growth rate of CPs expenditure on the Public Sector

In this sub-section, an attempt is made to measure the growth rate of CPs financial resources passing through the public health system. As earlier stated, the Zambian health SWAp utilises 3 financing mechanisms one of which is pooled basket funding in support of districts, second level and tertiary hospitals, training institutions, MoH headquarters, Medical Stores Limited and the Zambian National Blood Transfusion Service (statutory board). Initially basket support only covered districts (from 1993 to 2002) but second level and tertiary hospitals and MoH headquarters were included in 2003, and training institutions, Medical Stores Limited and the Zambian National Blood Transfusion Service in 2004. In this regard, one can assume that the basket was expanded vertically to cover more health facilities/institutions and that more monies should have been allocated to the basket.

Figure 12: Growth rate of CPs support through MoH Accounts: Zambia 1997-2005



	1997	1998	1999	2000	2001	2002	2003	2004	2005
%age Change in Basket Funds		121%	43%	108%	-14%	65%	51%	-19%	35%
%age Change in Other Funds		236%	98%	-10%	13%	50%	211%	115%	-21%
Total %age Change in Funds Through MoH Accounts		144%	58%	67%	-9%	61%	86%	29%	1%

Data Source: CBoH Accounts 1997-2005

The results in Figure 12 shows instability in the growth of all the funds that were passing through the MoH accounts between 1997 and 2005. Firstly, it is shown that the percentage of funds passing through the MoH accounts grew by 1% between 2004 and 2005 as compared to 144% between 1997 and 1998. Computation of the average growth of funds during the entire period 1997 to 2005 showed that the change was 55%. Earlier work on the

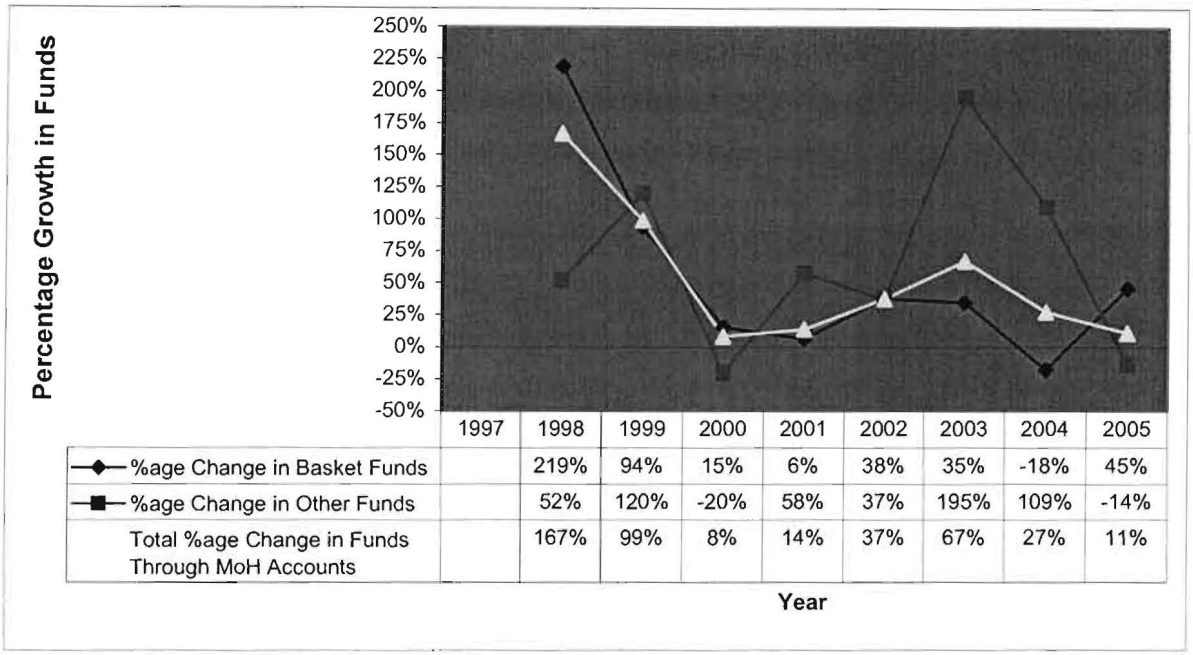
planning and management of external aid for health in Zambia that had been done by Mtonga (n.d.) showed that the change in CPs funding between 1990 and 1992 9before the SWAp) was on average –3%. This means that before the SWAp the CPs were reducing their assistance to the health sector and that after the adoption of the SWAp, CPs funding to the health sector has been growing significantly.

As regards basket funding, there was no basket funding before 1993 and its only logical to assume that the percentage change in 1993 over 1992 was 100%. However, between the period 1997 and 2005 the change in basket funding had been on average 49% as compared to the percentage change in other funds which was 87% over the same period. This means that basket funding has been growing at a slower rate than other funds (vertical programmes). A critical look at the trend in the growth of basket funding also shows that the change in basket funding in 1998 and 1999 were two times less than the changes in other funds.

The above finding can be linked to the partnership problems that were experienced between 1997 and 1999 whereby the CPs were reluctant to submit all their monies to the basket and opted to use other funding arrangements through vertical programmes. After the resolution of the partnership problems in the SWAp in 2000, more monies must have been allocated to the basket as the change between 1999 and 2000 was 108% while there was a decline of 10% in funding in other funds. On the other hand, basket funding only grew by 51% in 2003 despite the inclusion of tertiary hospitals and MoH headquarters as beneficiaries as compared to a growth of 65% in 2002 when only the districts were benefiting from the basket. Relatedly, basket funding declined by 19% in 2004 even with the addition of more beneficiaries (Training Institutions, Medical Stores Limited and the Zambian National Blood Transfusion Service). A re-look at the trend in other funds in 2003 and 2004, shows that increments of 211% and 115%, respectively, were recorded as a result of the coming in of the Global Fund (GFATM) and other global initiatives which don't pool resources.

Figure 13 below exemplifies the above analysis by including GRZ funding. The Figure also shows instability in the growth of funds even though each funding source was sustained throughout the review period. In relation to the partnership problems that were experienced between 1997 and 1999 and when some CPs had withdrawn funding, it appears that GRZ had responded by increasing its allocation to the basket such that the growth of basket funding in 1998 and 1999 surpassed the changes in other funds. However, the increased growth in other funds as a result of the global health initiatives is still dominant even if GRZ funds are added.

Figure 13: Growth rate of Support through MoH Accounts (CPs & GRZ) Zambia 1997-2005



	1997	1998	1999	2000	2001	2002	2003	2004	2005
%age Change in Basket Funds		219%	94%	15%	6%	38%	35%	-18%	45%
%age Change in Other Funds		52%	120%	-20%	58%	37%	195%	109%	-14%
Total %age Change in Funds Through MoH Accounts		167%	99%	8%	14%	37%	67%	27%	11%

Data Source: CBoH Accounts 1997-2005

The findings above demonstrate that a strong partnership is one of the key requisites of a successful SWAp. Further, supporting a set of common activities as envisioned through the SWAp can increase sustainability in programme funding owing to the fact that GRZ did take up the task of funding the programmes when the CPs reduced their support. The other issue is that funding to the basket has not increased despite the vertical expansion of the basket implying that pure re-shifting within the same cake is what has transpired. On the other hand, funding for programmes outside the basket continue growing far beyond that which goes to the basket implying that more and more programmes that are financially unsustainable are being funded. Some of the CPs interviewed that are involved in the funding of these programmes actually indicated that they were fully aware that the programmes which they were managing would not be sustained at the end of their tenure. One of the reasons that was mentioned was that the amount of money that was being used by vertical programmes was too enormous for GRZ and other pooling CPs to mobilise when the programmes ended. The other reason was that GRZ was unaware of the programmes and systems that were being implemented on the ground.

5.3.3.4 Exit Strategy and short-term Sustainability

The examination of the growth of funding above leads us to another important issue within the context of a SWAp. While it is imperative to examine the growth of resources over time, the quest for money should not overshadow critical policy decisions about how CPs should exit the health sector and availability of short-term mechanisms that could mitigate sudden disruptions in programme implementation.

In line with the requirements of the MoU, a CP that wishes to pull out of the health sector due to the expiry of support and/or any other reason is required to give 30 days written notice to MoH and other CPs in the SWAp. This includes a de-briefing and preparation of an exit strategy. In addition, funds committed and deposited in the basket accounts should not be claimed back. This agreement ensures short-term sustainability in the funding of programmes and it appears that this agreement is adhered to in the Zambian health SWAp. For example, DANIDA which was one of the pioneers of the Zambian health SWAp gave notice of its intention to exit the Zambian health sector in December 2005 by de-briefing all members in the health SWAp. DANIDA highlighted their main reasons to exit the health sector as completion of support of their Health Sector Programme Support (HSPS) and adoption of Harmonization in Progress (HIP) ideals. Having been informed, the other CPs in the SWAp were willing to take up the funding of programmes that DANIDA had been funding through the basket.

The other feature of the Zambian health SWAp is a six months buffer that takes care of short-term variations in funding that might arise due to withdrawal of CP support. The buffer had been working well and it was disclosed by an official from MoH that by mid 2004, the money in the buffer actually grew to an extent whereby sudden shocks in funding for a period of nine months could be taken care of. However, the buffer is not long-standing and cannot take care of long term losses in funding. In addition, it also overlooks sudden but drastic changes in funding such as the fluctuations in international exchange rates. For example, an unanticipated 40% appreciation of the Zambian Kwacha against all the major currencies in October 2005 led to a drastic loss in funding to an extent whereby money from the buffer was depleted by 50%. This is because close to $3 million was being used (since October 2005) to maintain the same value of the Kwacha before disbursement were made to beneficiary institutions (observation at January 2006 policy meeting). By March 2006, the MoH had predicted that there would be a deficit of $7 million in the basket and that more monies had to be mobilised if the full March disbursement to basket beneficiaries was to be sent.

5.3.4 EQUITY OF ACCESS

This section looks at the contribution of the health SWAp to improving geographical access to health care resources. Focus was narrowed down to the supply side vis-à-vis the provision of more opportunities for the rural areas so as to improve geographical (urban/rural) equity. The indicators that were looked at include the use of needs-based resource allocation formulae, Population to Staff ratios, distribution of health facilities, Fully Immunisation Coverage and Institutional Deliveries.

5.3.4.1 Use of needs-based Resource Allocation Formulae

According to the draft health care financing policy (Ministry of Health, 2005a), up until 2004 crude resource allocation formulae were used to allocate resources to districts and these mainly applied district populations weighted for population density and the presence of a second or third level hospital. With time, more parameters were added to account for cost differentials such as proneness to certain diseases, proximity to a bank and a fuel service station. Despite the numerous adjustments, however, all the district resource allocation formulae that were employed did not adequately address the concept of equity and need. Specifically, the resource allocation criteria were criticised for not being flexible enough to address the varying levels of deprivation and vulnerability, the utilisation of inputs such as human resources, existing number of health facilities and disease burden.

In view of the above, a Resource Allocation Committee (RAC) was constituted as a sub-committee of the SWAp coordination structures (specifically the Health Care Financing committee) in 2002 to spearhead the development of objective criteria for allocating resources for recurrent costs to districts, second and third level facilities. The work of the committee culminated into the development and application of a new resource allocation criterion for the districts in 2004. The new formula took into consideration 3 data sets (Living Conditions Monitoring Survey of 1998, HMIS and Census of Population and Housing of 2000) from which a weighted Material Deprivation Index (MDI) that incorporated the prevailing poverty situation, disease burden and the weighted population was constructed.

The RAC only went as far as developing a formula for the districts and as a result, the resource allocation formula for districts is the only objectively developed resource allocation formula and all the other levels still use crude formulae. For example, at second and third level hospitals, the population capacity and bed occupancy rate, respectively, are used as criteria for allocating resources. For training institutions, the number of graduates produced by each institution during the previous year is used.

However, even with the application of the new resource allocation formula for the districts (from the centre to the districts), there are no allocation formulae within the districts themselves. As such, the allocation of resources within the districts is still based on guidelines (developed at MoH headquarters) which specify the proportions of resources to be spent at the district office, district level hospital, health centres and health posts. The implication of this is that although the SWAp has encouraged an objective re-distribution of resources from the centre to the districts, the resources have not been satisfactorily targeted towards the indigent and vulnerable groups at community level. Further, there are no formulae from the centre to other levels meaning that resource allocation still remains a challenge in the financing of health services in Zambia.

5.3.4.2 Population to Staff Ratio as an indicator of Equity of Access

Table 14 below complements the arguments on inadequate human resources that were provided in sub-section 5.3.2.2. The Table shows the changes in core human resources engaged through the public health system between 1991 and 2005. The interpretation is that the population per staff ratio only reduced for Environmental Health Technicians (88%) and Paramedical Staff (42%) between 1991 (pre-SWAp) and 2005 (post-SWAp). On the other hand, the ratio increased by 58% for Clinical Officers; 36% for Nurses; 34% for Midwives; 31% for Pharmacists/Pharmacy Technicians; 9% for Laboratory Staff; and 5% for Doctors. Between the two periods, the staffing levels were also above the WHO recommended ratios for Doctors, Clinical Officers, Nurses and Midwives.

Table 14: Changes in Staffing Core Human Resources 1991 and 2005 (Public Health System)

	ACTUAL 1991	ACTUAL 2005	POPULATION - STAFF RATIO (1991)	POPULATION - STAFF RATIO (2005)	WHO RECOMMENDED POPULATION - STAFF RATIO
Doctors	508	646	15,817	16,652	5,000
Paramedical Staff	237	545	33,904	19,738	
Pharmacists/ Pharmacy Technicians	90	92	89,281	116,926	
Environmental Health Tech.	68	750	118,166	14,343	
Clinical Officers	1,372	1,161	5,857	9,265	2,700
Nurses	6,335	6,244	1,268	1,723	700
Midwives	2,281	2,273	3,523	4,733	2,000
Laboratory Staff	339	417	23,703	25,797	
TOTAL	**11,230**	**12,128**			

Data Sources: Ministry of Health (1992); Ministry of Health (2005c)

The implication of the above is that in 2005, there was one doctor for every 16,652 Zambian citizens and this is more than three times the WHO recommended workload. For clinical officers, nurses and midwives, the ratios were 3.4, 2.5 and 2.4 times more than the WHO recommended workloads, respectively. This suggests that Zambia has less than a third of the required Doctors and clinical officers. For nurses and midwives, Zambia has less than half of the required numbers.

A critical analysis of the imbalance in staffing between rural and urban areas actually reveals that the situation is worse in rural area. The capital city Lusaka and the Copperbelt province had moderately high staffing levels and therefore, the national average was actually masking the deplorable situation in rural areas. The average population per doctor rises to 36,712 against a target of 5,000 if Lusaka and the Copperbelt provinces are removed. This is 7.2 times more than the recommended WHO figure.

It is clear from the above that Zambia's current staffing levels cannot guarantee quality health service delivery and that the adoption of the SWAp has done almost nothing to address the situation and in fact, the situation has actually worsened. At the moment there are more core health workers in urban areas as opposed to the rural areas where the people who need more health services, due to high poverty levels and greater incidence of disease, reside. As a matter of fact, several interviewees pointed out that the lack of support for human resources was one of the major shortcomings of the Zambian health SWAp. The argument is that since the adoption of the health SWAp, minimal support for human resources has been provided despite the increased workload due to the HIV/AIDS pandemic. Thus, internal and external migrations are still rampant leading to an inequitable distribution of human resources.

5.3.4.3 Supply/distribution of health facilities as an indicator of improved access

In order to improve the physical proximity to health facilities, especially in rural areas, the findings revealed that the government had stuck to its policy of providing basic health through the rehabilitation and construction of health centres and health posts. Whereas there were 796 government owned health centres in 1990 (Ministry of Health, 1992) the number of health centres increased by 32% to 1,052 in 2002 (Central Board of Health, 2003). The MoH further indicated that 88% of the new constructions (137 new facilities) were built in rural areas (Ministry of Health, 2003). On the CPs side, it was established that only 10% of the annual basket funds was capped to be used by districts for rehabilitation and expansion of existing infrastructure.

The general indication was that more money was being provided for operational costs through the SWAp pool and vertical programmes than for capital development. To this effect, several CPs that were interviewed indicated that the SWAp had seriously de-capitalised the health system by focusing more on recurrent operational costs than on capital development. This is illustrated in Box 5.9.

Box 5.9: Key Informant on Capital Development

"Issues of equity have to do more with capital because where people work is where we transform money into services. If a district has more facilities we have to give it more money for operational costs as compared to the same type of district with fewer facilities. We have to give the district with fewer facilities money for capital development. This is why the capital fund was initiated in 2004 to develop these districts. But there is a human resources crisis and people won't go there even if we build more facilities. Therefore, you need to distinguish between equity and efficiency. Given the inadequate amount of resources at the disposal of GRZ, the desire is to incline more towards efficiency. But you need to strike a balance between efficiency (providing more money for operational costs) and equity (capital development)". ***MoH Official***

The above analysis suggests that efforts to improve geographical access to first contact health facilities is still not fully realised. As such, lack of physical proximity to health facilities still remains one of the major hindrances to accessing health services in Zambia. A recent survey by the Central Statistical Office (2004) showed that only 69% of the households were living within a radius of 5 km to a nearby health facility (Table 15). The situation in rural areas was actually graver than in urban areas in that only 54% of the households were within 5km proximity as compared to 99% in urban areas. This further implies that though the government has built more health centres in the rural areas during the SWAp implementation period, the distance to facilities in rural areas may not have significantly reduced. Regrettably, there was no data as to what the situation was before the SWAp. Even so, according to the World Health Organisation, all individuals should reside within 5Km of a health facility.

Table 15: Percent Distribution of Households by Proximity to Health Facilities Zambia 2002-2003

Residence	0-5 Km	6-15 Km	16+ Km	Not Stated	Total	Total No. of Households Surveyed
All Households	69	22	8	0	100	2,005,677
Rural	54	34	12	1	100	1,329,702
Urban	99	1	0	0	100	675,975

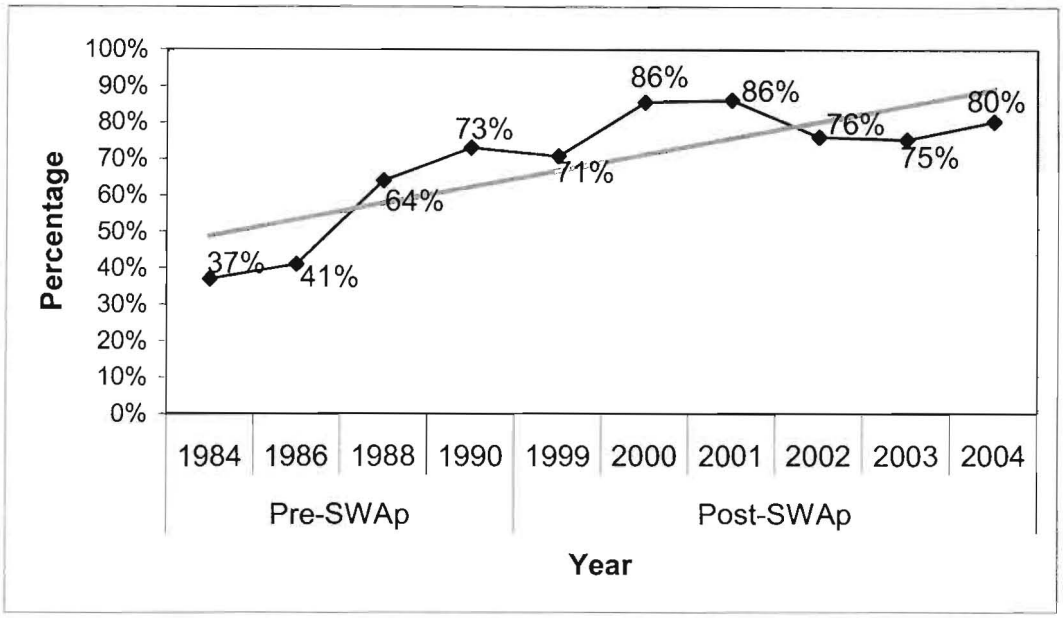
Source: Central Statistical Office, 2004

It appeared that all stakeholders in the SWAp have recognized that there was minimal support for capital development of which a policy decision was passed during the August 2004 policy committee meeting to operationalise a capital development fund for districts. Since then, US$ 200,000 per month was being set aside for capital development and by March 2006 US$ 2,800,000 had been saved. At the time of the research, the money was still lying idle as MoH had not yet come up with a capital development plan.

5.3.4.4 Health Status' of Children as an indicator of improved access

The initiation of an immune response through vaccination is a widely accepted public health strategy for the prevention of vaccine-preventable infectious diseases (Central Statistical Office, 2004). The Zambian interpretation of a fully immunised child is that a child aged below the age of one should receive one dose of BCG, three doses each of DPT and polio vaccines and one dose of measles vaccine (ibid). Figure 14 below shows that the percentage of fully immunised children (FIC) has been going up and that in 2000 and 2001 the coverage was 86% coverage but the figure dropped to 80% in 2004. Whereas the figures before the SWAp were below the national target of 80% coverage, the figures after the adoption of the SWAp were in most cases above the target except for 1999, 2002 and 2003.

Figure 14: Full Immunisation Coverage: Zambia 1984-2004

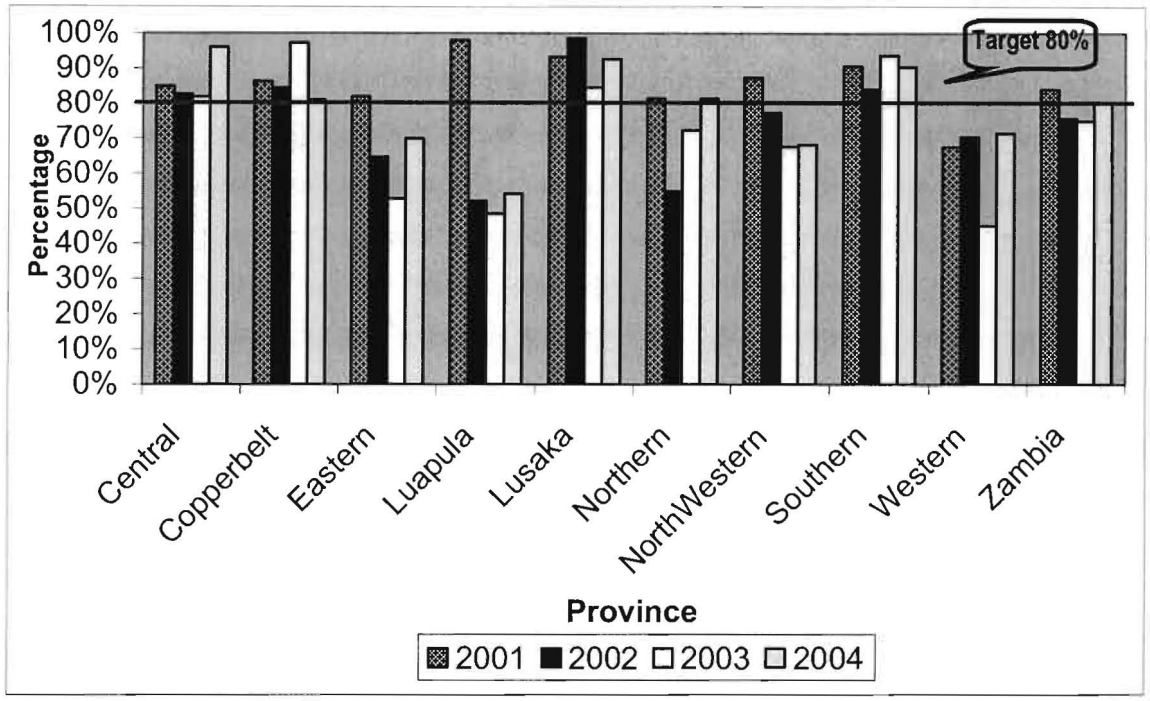


Data Sources: Ministry of Health, 1992; CBoH HMIS Indicators 1996-2005

Though it is difficult to draw a line on whether its purely SWAp and its benefits or the increased earmarked funding from vertical programmes such as GAVI/UNICEF, the interviewees specifically pointed out that the improvement can be attributed to the SWAp which had developed capacity at district level for micro-planning. One of the respondents (Bilateral CP) made reference to a Consultant that had been engaged to look at the transport management system in the health sector in 2003 and who had indicated that for 20 years that she had been working closely for districts across the African continent, the capacity of district planning that she had seen in Zambia was the best that she had ever come across. Under the SWAp, it had also been possible to improve the provision of routine immunisation in the facilities and this includes the procurement of more fridges and repairing of faulty equipment, capacity building for cold chain technicians and review of guidelines on the Expanded Programme on Immunisation (EPI).

From the foregoing, it is acceptable to indicate that fully immunisation coverage had improved during the SWAp implementation period due to new systems and transport (procurement of motor bikes and eight-six (86) 4X4 vehicles district-wide for utility and outreach) services that have been provided. In terms of staff motivation, interviewees pointed out that a good package of incentives to health workers such as field allowances was in place and that this motivated health workers to work harder. However, the synergy of the SWAp with other vertical programmes cannot be underestimated. For example, routine immunization services are complemented by mass immunization campaigns and resources are drawn from a range of vertical programmes. This to some extent suggests that the SWAp works more effectively when there is some level of verticalisation i.e. synergy with vertical programmes. However, this angle is beyond the scope of this paper.

Figure 15: Full Immunisation Coverage 2001-2004 by Province



Data Source: CBoH HMIS Indicators 1996-2005

In order to find out if there has been geographical equity of access, a re-look at the national immunisation coverage levels by province was made. The revelation was that in essence, the national figure was blanketing differences in the immunisation coverage in respective provinces. Figure 15 above unmasks this. The results shows that rural provinces such as Eastern, Luapula, Northwestern and Western had been recording immunisation coverage levels of less than the targeted 80% between 2002 and 2004. This is in contrast to urban provinces such as Central, Copperbelt, Lusaka and Southern provinces which had coverage levels of more than 80% throughout the period 2001 and 2004. The problem of low immunisation coverage in rural provinces was explored and the reasons that were given were lack of access to health facilities due to distances and the non-availability of vaccines. Notwithstanding the effect of distance on access, the later seems to have been the case as several interviewees pointed to this fact. This implies that the SWAp had not really contributed to the correction of geographical (urban/rural) in the targeting of resources to rural areas towards the attainment of universal fully immunised children.

5.3.4.5 Health Status' of Women as an indicator of improved access

Through the SWAp and other vertical programmes, considerable attention has been given to reproductive health (RH) programmes. This includes erection of maternity wings in several provinces, establishment of centres to facilitate safe blood transfusion in all provinces and extension of 58 health centres to include maternal health services in Eastern, Lusaka and Copperbelt Provinces. A recent study by Dunlop et al (2005) that looked at the resource flows to reproductive health services in Zambia through basket funding and other

mechanisms also indicated that partial tracking of specific RH vertical programmes' expenditures for seven (7) CPs amounted to US$ 3 million to US$ 5 million per year (0.1% of the share of the GDP going to health). On the other hand, an analysis of the flow of resources through the SWAp (basket funding) showed that 16-36% of all the essential drugs were for RH just as 79% of the drugs in the drug kits were RH related. It was also established that 34-50% of all the services that are provided at district level were RH related.

Given the above interventions through the SWAp and other vertical programmes, the investments seem to have slightly paid off as the national antenatal coverage has been relatively high (94% on average) during the period 2002 to 2004. A review of the number of institutional, traditional and supervised deliveries between 2002 and 2004 (Table 16) also showed that the figures had been increasing steadily. The results show that the number of institutional deliveries at national level had increased slightly from 35.3% in 2002 to 43% in 2004. However, if a comparison is made to baseline data (before the SWAp), there is really nothing much to talk about. This is because in 1992, the number of institutional deliveries was estimated at 50.7% (Central Statistical Office, 1993) as compared to 43% in 2004 (after the SWAp).

Table 16: Percentage of Institutional (Inst.), Trained Traditional Birth Attendants (tTBAs) and Supervised Deliveries (incl. tTBA): Zambia 2002-2004

Province	Institutional (Inst.)			(tTBA s)			Supervised (inst. & tTBAs)		
	2002	2003	2004	2002	2003	2004	2002	2003	2004
Central	22	31	39	9	9	20	31	40	59
Copperbelt	54	69	56	8	12	11	62	81	67
Lusaka	49	47	53	1	1	2	50	48	56
Southern	31	33	37	18	21	26	49	54	63
Eastern	26	32	38	17	21	21	47	53	59
Luapula	30	32	32	21	21	23	51	53	56
Northern	28	30	31	16	21	26	44	53	57
North Western	40	45	47	18	21	22	58	66	69
Western	38	32	48	12	15	18	50	47	66
Zambia	**35.3**	**39**	**43**	**13.3**	**15.8**	**18**	**49.1**	**55**	**61**

Source: Central Board of Health, 2005

In terms of urban/rural differentials for institutional deliveries, in 2002, only two out of the four urban provinces (Copperbelt and Lusaka) ranked first and second while Southern was fifth out of all the nine provinces and Central province the worst out of all the nine provinces. In 2004, the situation still remained the same for Copperbelt and Lusaka while Central province improved to claim the fifth position with the situation in Southern province deteriorating from fifth to seventh. On the other hand, only Western and Northwestern provinces were doing well out of all the rural provinces, positioning themselves at third and fourth in 2002 and 2004.

The implication of the above finding is that the SWAp had not made notable contributions to addressing geographical inequities among women. This is because there were generally more institutional deliveries in the urban provinces in comparison to the rural provinces. However, some of the urban provinces were also under performing.

The scenario during the SWAp implementation period seems to be inclined towards the training of more trained Traditional Birth Attendants (tTBAs) to ease the human resources crisis (shortage of midwives and nurses) as the figure for active tTBA was 2,154 in 1991 (Ministry of Health, 1992) as compared to 4,995 active tTBA in 2004 (CBoH HMIS Indicators 1996-2005). It is not surprising, therefore, that the percentage of deliveries by tTBA went up from 9.4% in 1992 (Central Statistical Office, 1993) to 18% in 2004 (CBoH HMIS Indicators 1996-2005).

In a nutshell, contrary to the views that a SWAp does not pay attention to priority health interventions, it appears that massive investments through the SWAp and other vertical programmes had been provided to RH activities in Zambia even though there has been no meaningful improvement in maternal health. The issue of a SWAp paying less attention to priority health interventions might not hold in Zambia as most of the respondents ardently indicated that most of the priority public health diseases such as Malaria, HIV/AIDS, TB, Child Health and RH were receiving a lot of support from the SWAp as well as other global health initiatives such as GFATM, Stop TB, UNFPA, GAVI, PEPFAR, etc.

5.4 SUMMARY OF THE CHAPTER

A detailed analysis and discussion of the individual elements of the Zambian health SWAp and their contribution to the delivery of health services were provided in the preceding chapter. Firstly, I appraised the content and scope of the Zambian health SWAp and secondly, how the implementation of each of the individual elements of a SWAp had fostered working relationships and strengthened mechanisms for aid management. In terms of breadth, I found out that all the five core elements of a SWAp were existing in the Zambian health SWAp with variances on the degree of depth towards the implementation of each of the individual element vis-à-vis the level of participation and ownership.

In evaluating the contribution of the health SWAp as a whole to improved service delivery, I looked at the impact of the SWAp on accountability for finances and progress, efficient allocation and use of resources, financial sustainability and promotion of geographical equity of access to health care resources. The major findings were that the SWAp had significantly contributed to improved financial management and accountability but this was not the case in the area of procurement and accountability for performance. Further, the SWAp mechanism as a whole had not really made any notable contributions to improving administrative,

technical and allocative efficiencies. Transaction costs were still high; there were a number of CPs using separate systems; the productivity of district hospitals was below par; and the distribution of GRZ resources among competing users was sub-optimal both in terms of budgeting and execution.

Instabilities in the growth of funds from all sources were identified and that basket funds were growing at a slower rate than funding for vertical programmes. Coupled with this was GRZ's inability to meet regional targets for funding the health sector. However, it established that implementation of the SWAp had played a major role in promoting equity in the allocation of resources to districts through the use of a needs-based resource allocation formula but that formulae had to be developed for the other levels. Lastly, it was noted that the SWAp had made minimal or no contributions in terms of correcting geographical inequities (urban/rural) in the targeting of resources towards the attainment of universal fully immunised children and institutional deliveries among women. Contextual/underlying factors that negated the attainment of geographical equity of access include the lack of human resources, lack of physical proximity to health facilities, and shortage of vaccines for child immunisation to mention but a few.

CHAPTER SIX: CONCLUSIONS, POLICY RECOMMENDATIONS AND AREAS FOR FUTURE RESEARCH

6.0 INTRODUCTION

This chapter provides the concluding remarks, associated policy recommendations and areas for future research. The conclusions covers all the five thematic areas that the study intended to appraise as well as other emerging issues. Realising that effective implementation of a health SWAp still remains a challenge to the Zambian government, a comprehensive list of policy recommendations have been suggested based on the study findings and conclusions. The idea is to allow MoH through the SWAp coordination unit to decide on what to implement, through prioritisation in the interim to long term although suggested priorities are presented. The study also unveiled certain areas requiring future research which are also presented in this chapter.

6.1 CONCLUSIONS AND POLICY RECOMMENDATIONS

6.1.1 Content and Scope of the Zambian Health SWAp

The Zambian health SWAp can be regarded as a full SWAp whose implementation has developed gradually and consultatively. The whole approach tries to maximise partnerships between GRZ and CPs in the use of national systems as much as possible. In terms of breadth, it was apparent from the analysis of the results that all the five core elements of a SWAp were present in the Zambian health SWAp. An evaluation of the individual elements of the health SWAp, however, revealed that varying degrees of successes and failures have been achieved when it comes to the implementation of each of the individual element of the SWAp. Some of the areas where not much had been achieved include the implementation of a MTEF budget and use of harmonised implementation mechanisms and procedures. Further, three (3) financing mechanisms were in existence most of which were not aligned to the budget. In addition, some of the vertical programmes were not in support of the NHSP save for pooled funding which only meets a fraction of activities contained in the NHSP. Further, there are no synergies in the financing and procurement of drugs making it difficult to procure drugs efficiently.

Policy Recommendation

- There should be continued strengthening of shared processes and approaches for implementing and managing the sector strategy and work programme. This includes development of a code of conduct and refinement of the SWAp coordination structures particularly the MoU, policy framework and the MTEF.

- It is vital that MoH immediately works out modalities for aligning all forms of financing to the NHSP and budget in order to be more efficient in the provision of services. This includes the creation of synergies in the financing of drugs and medical supplies through the operationalisation of the proposed Drug Supply Fund.

6.1.2 Ownership

Evidence had suggested that the Zambian health SWAp was sector narrow both in terms of stakeholder and consumer involvement as well as the range of programmes/activities that were being supported. From the general stakeholders' perspective, the Zambian health SWAp is sector narrow towards the public sector and also within the public sector itself to an extent whereby people only equate it to pooled funding and as a limited approach to increasing the administrative capacity of the districts. Even so, the SWAp appeared to have been built on decentralisation and it adequately makes use of the decentralisation process.

Though non-pooling CPs satisfactorily participate in the SWAp coordination meetings, their voice was found to be less influential as compared to pooling CPs. In this regard, pooling CPs were closer as allies to MoH than the non-pooling CPs. Further, the pooling CPs were to a greater extent more committed to the SWAp process and development of the health sector as a whole than the non-pooling CPs.

Concerning government ownership of the SWAp process, it was apparent that though it provides leadership in the SWAp process, it's not completely in control as it doesn't fully sanction all the key decisions. The CPs are heavily involved in policy making mainly in the interest of making sure that the set objectives are met but sometimes in order to meet the mandate of their missions.

Policy Recommendations

- Government should strive to pull all stakeholders on board and should show ownership by being firm when it comes to making major policy decisions. This entails gaining the confidence of all stakeholders in the health sector through wider stakeholder consultation and consensus building.
- Decentralised structures through which the SWAp operates at community levels should be strengthened so that consumers of health services can have a say on the quality of health services provided. This can be done through routine consumer based quality assurance surveys.
- The range of activities supported by the SWAp should be increased in order to accommodate both the private and public sectors, and all levels of the health care delivery system.

6.1.3 Transparency and Accountability

The adoption of the health SWAp has to a large extent contributed to improved financial management and accountability even though more has to be done in the area of transparency and accountability in procurement. The other issue was accountability for performance which was found to be lacking. The health system as a whole was not performance oriented and there were very modest incentives within the system for officers to actually provide the results.

Policy Recommendations

- Notwithstanding the improvements in financial management and accountability, audit systems need to be strengthened so that they do not only address compliance to financial management procedures but also the effectiveness of risk management and governance processes. As such, non-financial audits including value for money, forensic and electronic audits should also be conducted.

- There is a need to further strengthen the capacity of the various procurement units and tender committees at all levels of the health care delivery system. This includes training of staff and putting in place good procurement systems that would strengthen the management of the procurement cycle, record keeping, fiduciary arrangements and outsourcing.

- To improve the performance of the health sector, there is a great need to put in place a viable performance management system that would make it possible to account for performance with a focus on service delivery. The starting point would be to set priorities on what should be achieved, timeframes and performance incentives to be rewarded. The establishment of a performance based incentive system would help in setting standards for work, compliance to work programmes and getting away from reporting for the sake of reporting to reporting for the sake of proving performance.

6.1.4 Transaction Costs (Administrative Efficiency)

The SWAp had not done much in improving administrative efficiency as transaction costs were found to be very high owing to the number of meetings and their comprehensiveness, and the number of CPs using separate systems. Instead of moving towards harmonised support, the number of global, multilateral and bilateral projects has increased that mainly cover HIV/AIDS programmes/activities and not a range of public health interventions.

Policy Recommendations

- MoH and its CPs should further streamline the number of SWAp meetings especially the monthly policy meetings which should be held quarterly. With respect to the monitoring and evaluation meetings, it is proposed that these meetings are held

fortnightly. It is assumed that with fewer meetings, there will be more focus in these meetings and that MoH officials will be allowed more time to do their normal work.

- Related to the above, CPs using separate systems should be discouraged from doing so by engaging them more in the SWAp consultative process and change management processes towards harmonised sector support.

6.1.5 Technical Efficiency

It was established that the SWAp mechanism as a whole had not done much in improving technical efficiency due to lack of support for human resources and drugs. Specifically, the productivity of district hospitals had not been optimized while the health centre daily client contact rates were going up.

Policy Recommendations

- Human resources being a key requirement for service delivery, more support should be provided through the SWAp to human resources in the form of performance based financial incentives and non-monetary incentives like staff housing, solar panels, transport etc. The existing rural retention schemes for doctors should be extended to all health cadres in hard to reach areas. This also goes for other cost items like drugs which are enormously under funded.

6.1.6 Allocative Efficiency

During the SWAp, the distribution of GRZ resources among competing users was found to be sub-optimal in terms of budgeting and execution. In particular, the GRZ budget was found to be unrealistic as the SWAp guidelines on resource allocation by level of health care were not being followed and that there was an inclination towards the allocation of more money to districts at the expense of other levels, especially second and tertiary hospitals. On the other hand, a critical look at the execution of the budget revealed that actual releases from GRZ didn't match budget estimates and that receipt of the funds was unpredictable. The CPs on the other hand were performing above expectation and in most instances, disbursement were more than the budgeted amounts. Further, there were few negative variations in budgeted amounts against the actual releases for basket funds in comparison to vertical programmes. This suggests that pooling CPs were more committed to the health sector than those running vertical programmes and projects.

On the other hand, it was established that priority setting and resource allocation was in line with the requisites of the Basic Health Care Package (BHCP) though the amount of resources at the disposal of GRZ was inadequate to meet all the requirements of the BHCP.

Policy Recommendations

- MoH and its CPs should revise its budgeting process by appropriately funding the secondary and tertiary levels of the health care delivery system in accordance with the set guidelines if quality health care is to be provided.
- In order to attain marked improvements in service delivery, national systems should be reinforced so that there is regular and predictable funding. This includes making close follow up as to when funds are disbursed from the Ministry of Finance to MoH and that the rightful amounts of money are disbursed on time from MoH to beneficiary institutions.
- GRZ should provide adequate resources to cover all the components of the BHCP considering that provision of basic and cost-effective interventions through the BHCP would impact more on the poor.

6.1.7 Financial Sustainability

The private sector and the CPs were found to have ventured more into the financing of the health sector during the SWAp implementation period than before. Funding from GRZ was found to be erratic and not in accordance with the requirements of the Abuja Declaration which calls for African governments to spend 15% of their discretionary budget on health. GRZ, however, did adequately take up the responsibility of funding the health sector in times of partnership difficulties signifying that supporting a set of common activities as envisioned through the SWAp can increase sustainability in programme funding. However, with renewed partnerships and commitments by CPs, funding from the GRZ was found to be fungible. MoH was generally regarded by GRZ to be donor-congested and over the last few years it had been getting progressively less money from GRZ as compared to other social sectors.

There was instability in the growth of funds from all sources even though each funding source was sustained throughout the review period. However, it was found that before the SWAp the CPs (all sources) were reducing their assistance to the health sector and that after the adoption of the SWAp, funding to the health sector has been growing significantly. Nonetheless, pooled basket funding was found to be growing at a slower rate than funds for vertical programmes and projects despite the vertical expansion of the basket. The striking observation was that funding to the basket had not really increased despite the vertical expansion of the basket. The continued growth of funding for vertical programmes meant that more and more financially unsustainable programmes were being funded.

A very good system meant to sustain operations in the health sector by way of a six-month buffer was in place even though it could only take care of short-term variations in funding. In

particular, it was discovered that the buffer couldn't take care of sudden but drastic changes in funding resulting from international exchange rate fluctuations.

Policy Recommendations

- GRZ should ensure that resource allocation matches agreed policies and regional declarations like the Abuja Declaration which calls for African governments to spend 15% of their discretionary budget on health. Increased GRZ funding would go a long way in improving financial sustainability and towards the attainment of the Millennium Development Goals.

- Much more needs to be done in resource mobilisation, say the introduction of viable community and/or social health insurance schemes, if basic health care is to be provided to all. Given the abolition of user fees at the primary health care level in April 2006, the importance of coming up with alternative health care financing mechanisms that can cover the loss of revenue from the user fees cannot be overemphasised.

- It is reiterated that MoH should align all funding sources to the MTEF and NHSP in order to stabilize the mix of funding from all sources.

- MoH should ensure that SWAp monies are protected against drastic foreign exchange fluctuations by tying the funds to a financial market through *forward contracts* and *options*. This is very important because most CPs monies are provided in dollars and in order to avert loss of money, MoH should hedge against this risk by committing itself to a future transaction through a *forward contract*. In the case of an *option,* MoH would have the right (but not the obligation) to buy/sell foreign currency at a specific price in future.

6.1.8 Equity of Access

The SWAp has made notable contributions to promoting equity in the allocation of resources through the use of a needs-based resource allocation formula for the distribution of resources from the centre to the districts. However, lack of resource allocation criteria within the districts still pose a challenge in the allocation of resources in the Zambian Health SWAp. It was also noted that the SWAp had not corrected geographical distribution of human resources as more health workers were in urban areas as opposed to rural areas. This has implications on the quality services for services provided in rural areas.

It was established that physical proximity to health facilities, especially in rural areas, was still a problem despite GRZ's commitment to providing basic health services through the rehabilitation and construction of more health centres and health posts in the rural areas. The underlying reason was that the SWAp has to a large extent de-capitalised the health

system by focusing more on recurrent operational costs than on capital development. In addition, geographical equity of access to basic health care among children vis-à-vis the fully immunisation coverage had not improved during the SWAp implementation period. This is evidenced from rural provinces such as Eastern, Luapula, Northwestern and Western which had low immunisation coverage levels partially due to lack of access to health facilities owing to distances and/or the non-availability of vaccines.

Through the SWAp and other vertical programmes, considerable attention had been paid to reproductive health (RH) programmes and the results showed that the number of institutional deliveries at national level has started improving in the last 3 years prior to the research. However, the national coverage rates before the SWAp were better meaning that nothing much has been achieved during the SWAp era. It was also leant that geographical inequities in institutional deliveries had not been addressed since the urban provinces were generally doing better than the rural provinces. The underlying reasons for the fall in institutional deliveries could be due to inadequate human resources (nurses and midwives) though this problem was partially being addressed through the training of more tTBAs during the SWAp implementation period.

Policy Recommendations

- It is suggested that needs-based resource allocation formulae within the districts should be developed so that the benefits of investment in health services are equitably distributed to areas of greatest need.
- MoH should ensure that there is a coordinated effort towards the capitalisation of the health sector through the SWAp if physical proximity to health facilities is to be reduced. The starting point would be the development of a capital development plan that should address issues related to health facilities, staff housing, transport and communication systems. The capital development plan should also be in line with human resource training, recruitment and retention as envisioned in the Human Resources for Health Strategic plan 2006-2010. In the interim, MoH should tackle the problem of lengthy distances to health facilities through improved outreach programmes and transport through the procurement of more motor bikes.
- MoH should strengthen the Expanded Programme on Immunisation (EPI), management of common childhood illnesses as well as put in place comprehensive maternal health services including Focused Antenatal Care (FAC) and family planning services. A rapid programme for training of more midwives should be put in place and in the interim, more traditional birth attendants should be trained as a temporary solution.

6.1.9 Emerging/overarching Issues

Contrary to the views that a SWAp doesn't pay attention to priority health interventions, it appeared that massive investments had been provided to RH activities in Zambia even though there had been no meaningful improvement in maternal health. The same can be said for other priority public health diseases such as Malaria, HIV/AIDS and TB which were receiving a lot of support from the SWAp as well as other global health initiatives. It was also noted that the Zambian Health SWAp appeared to be working well with vertical programmes.

6.2 SUMMARY OF KEY AREAS AND PRIORITY RECOMMENDATIONS

Presented in Table 17 below are some of the key areas and priority recommendations that MoH should immediately consider to implement in order to improve the operations to the health SWAp. It should be noted that the feasibility of implementing these recommendations requires extra financial resources from both the government and CPs, further harmonization and alignment of aid and improvement of management systems.

Table 17: Matrix of Key Areas and Priority Recommendations

KEY AREA	PRIORITY RECOMMENDATION
Financing Mechanisms	*MoH should immediately work out modalities for aligning all financing sources to the NHSP and budget in order to be more efficient in the provision of services. This includes the creation of synergies in the financing of drugs and medical supplies through the operationalisation of the proposed Drug Supply Fund*
Ownership	*Government should strive to pull all stakeholders on board and should show ownership by being firm when it comes to making major policy decisions*
Transparency and Accountability	*MoH should further strengthen audit and procurement systems at all levels of the Zambian health care delivery system* *MoH should put in place a viable performance management system that would make it possible to account for performance with a focus on service delivery*
Administrative Efficiency	*MoH should further streamline the number of SWAp meetings especially the Policy and Monitoring and Evaluation meetings* *MoH should discourage CPs using separate systems by engaging them more into the SWAp consultative process*
Allocative Efficiency	*MoH should revise its budgeting process and improve on budget execution in accordance with the set guidelines*
Financial Sustainability	*GRZ should increase its share of allocation to the health sector while at the same time introduce viable alternative health care financing mechanisms such as health insurance* *MoH should ensure that SWAp monies are protected against drastic foreign exchange fluctuations by tying the funds to a financial market through forward contracts and options*
Equity of Access	*A rapid training, recruitment and retention programme drawn from the Human Resources for Health Strategic Plan 2006-2010 should be developed and implemented. This should include a capitalisation plan and operationalisation of the proposed Drug Supply Fund*

6.3 AREAS FOR FUTURE RESEARCH

This study was concerned with the assessment of the individual elements of a SWAp and the SWAp mechanism as a whole on the provision of health care in Zambia. In the course of the study, certain issues came to the fore that require more research. These issues are highlighted below.

- It was recognized that the health SWAp was working more effectively when there was some level of verticalisation i.e. synergy of the SWAp with vertical programmes such as Reproductive Health. At the same time, global health initiatives were said to be threatening the existence of the health SWAp, due to the use of separate systems and huge amount of monies being channeled though the Zambian health sector. In this regard, detailed research is needed to evaluate the impact of global health initiatives on the health system so as to solicit ways of integrating and strengthening the synergies towards a sustainable health care delivery system.

- It was understood that the shift from SWAp to Direct Budget Support (DBS) is a natural progression that demonstrates donor confidence in the use of national systems. More research is needed on the potential gains and losses that will be incurred by moving to DBS, ideally government's level of preparedness and particularly if the health sector was ready to transit.

- A benefit incidence analysis through the use of asset indices and selection of one key public health intervention, say HIV/AIDS or Malaria, has to be done to find out if the health SWAp was pro-poor. Results from this research will make it easy to ascertain the degree to which resource allocation matched agreed policies and the impact of the SWAp on the poor.

- The other area of research would be to look at the interrelationship of the SWAp with the decentralisation process specifically the impact of the popular participatory structures on demand for and access to effective interventions.

- Lastly, given the lack of substantial evidence on health system performance, the other research need would be to do more evaluations of quality of health care, user perceptions, and sub-district resource allocation processes focusing more on service delivery.

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APPENDIX I – DESCRIPTION OF SWAP COORDINATION MEETINGS

(A) Minister of Health and Heads of Missions Meeting

This is a special meeting held annually during the third quarter of each year and is chaired by the Minister of Health. All Heads of Missions (both bilateral and multilateral) providing technical assistance to the health sector attend this meeting. The purpose of the meeting is two fold:

- It accords an opportunity to the various Heads of Missions involved in the health sector to convey to the Honourable Minister a joint statement on key policy areas of concern and priorities that should be addressed during the following year.

- Conveyance of commitment from the Honourable Minister to focus on addressing identified areas of concern and priorities during the following year.

(B) MoH/CPs Annual Consultative Meeting

An Annual Consultative meeting between MoH and its CPs is held during the first week of December every year and is chaired by the Honourable Minister of Health. The purpose of this meeting is as follows:

- Review action plans, and budgets for the following year submitted by MoH including tentative financial commitments from all CPs;

- Review the annual report from the previous year for MoH and CBoH and to assess overall sector performance;

- Review counterpart funds from MoH;

- Review pledges from CPs towards the annual action plans/MTEF; and

- Consider any changes to the multi-year NHSP although not expected to be substantially revised.

Composition

MoH – All Directors, Heads of Units, Chief Policy Analysts and senior planners

CBoH - All Directors, Head of Units and Specialists in category one, Provincial Health Directors and Provincial Financial Specialists

MoH Statutory Boards/Bodies – Executive Directors from: University Teaching Hospital, Chainama Hills Hospital, Zambia National Blood Transfusion Services, Medical Council of Zambia, General Nursing Council of Zambia, Medical Stores Limited, National AIDS/STI/TB Council and National Malaria Control Centre

Line Ministries - Ministry of Finance & National Planning, Ministry of Local Government and Housing, Ministry of Community Development and Social Services, Cabinet Office

Non-Governmental Organisations - Representatives from the Churches Health Association of Zambia, Health Systems Support Programme

CPs - Ambassadors, High Commissioners and Resident Representatives; First and Second Secretaries responsible for health, and Heads of the health portfolio for agencies e.g. USAID, GTZ, GFATM

(C) Health Sector Advisory Committee Meetings

Two Health Sector Advisory Committee meetings are held each year and are presided by the Permanent Secretary, MoH with full sector-wide participation including the civil society and private sector. The first meeting is held at the end of March and the second at the end of September. The purpose of the meetings are as follows:

March Health Sector Advisory Committee Meeting

- Review progress for quarter three and four for the previous year and approve disbursements for quarter three and four for the current year;
- Monitor selected number of performance indicators for quarter three and four for the previous year;
- Monitor GRZ and CPs' release of funds for quarter three and four for the previous year; and
- Review audit reports for quarter three and four for the previous year.

September Health Sector Advisory Committee Meeting

- Review progress for quarter one and two for the current year and approve funding for quarter one and two for the following year;
- Monitor selected number of performance indicators for quarter one and two for the current year;
- Monitor GRZ and Co-operating Partners' release of funds for quarter one and two for the current year; and
- Review audit reports for quarter one and two for the current year.

Composition

MoH – All Directors, Heads of Units, Chief Policy Analysts and senior planners

CBoH - All Directors, Head of Units and Specialists in category one, Provincial Health Directors, Provincial Financial Specialists and Provincial Data Management Specialists

MoH Statutory Boards/Bodies – Executive Directors from: University Teaching Hospital, Chainama Hills Hospital, Zambia National Blood Transfusion Services, Medical Council of Zambia, General Nursing Council of Zambia, Medical Stores Limited, National AIDS/STI/TB Council and National Malaria Control Centre

Line Ministries - Ministry of Finance & National Planning, Ministry of Local Government and Housing, Ministry of Community Development and Social Services, Cabinet Office, Central Statistics Office

Non-Governmental Organisations - Representatives from the Churches Health Association of Zambia, Health Systems Support Programme, PATH, JSI/Deliver, UPLIFT Zambia and representatives from the Civil Society.

CPs - Ambassadors, High Commissioners and Resident Representatives; First and Second Secretaries responsible for health, and Heads of the health portfolio for agencies e.g. USAID, GTZ, GFATM

(D) MoH/CPs Monthly Policy Meetings

Policy meetings between MoH and its CPs are held every last Thursday of the month (except for March, September and December) and are chaired by the Director of Planning and Development. However, at the end of each quarter, these meetings are chaired by the Permanent Secretary, MoH. The purpose of the policy meetings are:

- Review of the quarterly economic report to be presented to the Ministry of Finance and National Planning;
- Review of action taken and progress in implementing areas of concern and priority and as identified and agreed during the Annual Consultative meeting;
- Identify areas of concern that impede implementation of health services that require policy interventions of both MoH and CPs during the course of implementing action plans; and
- Agree on a course of action to be undertaken to resolve identified problems.

Composition

MoH – Members of the MoH and CBoH Senior Management Team

CPs – All First and Second Secretaries responsible for health, Heads of Agencies supporting the health sector

(E) Implementation Review Steering Committee (IRSC) Meetings

The IRSC meetings are held on Friday each week are internal meetings between MoH and CBoH. These meetings discuss and review all technical issues as they relate to health sector programming and the delivery of health services. CPs are not part of the IRSC meetings but are welcome to sit in as observers. More so, all the minutes and agenda of the IRSC meetings are availed to the CPs for information purposes.

(F) Monitoring and Evaluation (M&E) Committee Meetings

The M&E steering committee was formed in November 2002 and is chaired by the Director of Planning and Development from MoH with RNE and USAID as focal point CPs. The M&E steering committee draws membership from professionals from MoH, CBoH and CPs (DCI, DFID, EU, JICA, SIDA, UNFPA, UNICEF, WHO) and meets every Wednesday of the week to monitor the implementation of programmes as contained in the multi-year National Health Strategic Plans and annual action plans. In addition, the committee also reviews performance indicators, planning and budgeting processes, mode of support and other areas of concern that impede implementation of health services. The full mandate of the sub-committee is:

- Facilitating the development of joint health sector performance indicators;
- Development and coordination of joint implementation mechanisms as well as schedules/timeframes for conducting joint reviews, audits and assessments;
- Facilitating health sector performance reporting and dissemination of annual performance reports;
- Providing an overview on data collection and management; and
- Providing strategic direction on various data collection and analysis systems (routine, periodic, and special surveys/research).

The M&E sub-committee is extremely active and it works hand-in-hand with all the various Technical Working Groups (TWGs). During the years 2004 – 2006, it had been working on the

development of a Performance Assessment Framework that would pave way for the smooth implementation of Direct Budget Support.

(G) Capital Fund Technical Working Group

The Capital Fund TWG is chaired by the Director of Planning and Development from MoH with JICA and DFID as focal point CPs. The reference group is constituted by DANIDA, RNE, SIDA, MoH and CBoH. The Terms of Reference for the TWG are:

- Suggesting modalities and advise on the resource allocation, management and reporting for the capital fund;
- Development of an Institutional Development Policy for the health Sector.
- Listing possible challenges and constraints faced in the operationalistion of a capital fund;
- Suggesting the process and estimation of the requirements for formulation of a multi-year health equipment/transport rehabilitation and procurement plan;
- Producing feedback for ongoing activities under the capital fund including an account of time frames on monitoring and evaluation; and
- Production of the preventive maintenance policy for the capital fund.

The TWG has identified three areas to encompass work on establishing a Capital fund namely equipment, infrastructure, transport and communication.

(H) Human Resources Technical Working Group

The Human Resources TWG meets every Tuesday afternoon and is chaired by the Director of Human Resources & Development from MoH with SIDA and USAID as the focal point CPs. It draws membership from both the CPs and MoH and the reference group from the CPs is DFID, JICA, RNE, UNFPA, WB and WHO. The Terms of References for the TWG are:

- Collection and provision of information on the concept and operationalistion of a Human Resource Fund (HRF);
- Listing possible challenges and constraints faced in the operationalisation of a HRF;
- Working out the levels of annual investments required for the various types of cadres based on the Human Resource Strategic Plan; and
- Suggesting modalities for resource allocation, management and reporting of the HRF.

(I) Expenditure and Budget Technical Working Group

This TWG is ideally supposed to be chaired by the Assistant Director – Health Planning & Budgeting from MoH with SIDA as the focal point CP. At the time of the research, there was no indication of when the TWG last met and work achieved thus far. However, the Terms of Reference for the TWG are:-

- Collect data on various financial reporting formats from all stakeholders, evaluate each format, and determine its relevance to CPs/MoH requirements on expenditure information;
- Scrutinize government financial regulations and establish their implications on MoH meeting and its commitments to the MoU;
- Study in depth, health sector documents available that are relevant to the budgeting and Expenditure formats such as FAMS, NHA, JIP, I & E, IFMIS etc.
- Development of a joint reporting format; and
- Provision of information on the implications of the proposed format, indicating what resources and structures are required by MoH to ensure successful implementation.

(J) Service Delivery Recurrent Fund (SDRF) TWG

This TWG is scheduled to meet every fortnight on Thursdays at 10:00 hours. The TWG is essentially understood to be chaired by the Director General – CBoH with RNE as the focal point CP. At the time of the research, there was no indication of when the TWG last met and work achieved thus far. Further, it was not clear what the Terms of Reference for the TWG are but progress of work reported was as follows:

- Development of a discussion paper to give members of the committee plain concepts regarding the operation of the TWG; and
- Development of a conceptual framework indicating the various sources of money into the SDRF, how it will be re-allocated to different beneficiaries. It was indicated that the framework provides a rough guide on how the resources will be allocated to the different beneficiaries.

(K) Procurement Technical Working Group

The chairperson for the above TWG is the Head of Procurement & Supplies from MoH with CIDA and DFID as focal point CPs. The other members are drawn from MoH, CBoH, DANIDA, DCI, EU, JICA, RNE, SIDA, UNICEF, USAID and WB. The TWG is very active and meets every Thursday afternoon. The Terms of Reference for the TWG are:

- Collecting and providing an inventory of goods and services to be procured in the health sector. This includes sorting out the procurement overlaps between the MoH and CBoH procurement units and to make recommendations on the handling of bulk/strategic procurements;
- Facilitating the formulation of a Procurement Plan for the health sector;
- Listing possible challenges and constraints faced in the operationalistion of a procurement plan;
- Evaluating tenders and all procurement Memoranda of Understanding (MoUs) in the health sector;
- Making recommendations for the adoption of suitable procurement systems if the need to use an alternative procurement system arises;
- Making recommendations over the establishment of procurement units as well as the strengthening of existing ones. This includes building/rehabilitation of infrastructure, recruitment/capacity building for members of staff, and identifying procurement units eligible for higher thresholds with the Zambia National Tender Board; and
- Facilitating the monitoring and evaluation of procurement units by the Zambia National Tender Board.

APPENDIX II – POPULAR PARTICIPATORY STRUCTURES

District Health Boards (DHBs)

DHBs serve as the principal management units in the decentralised system and they govern the affairs of the district health service through the District Health Management Teams (DHMTs). Their responsibility is to ensure that local priorities are recognised and addressed, planning for the district, bringing on board other key sectors (education, social welfare, agriculture, local government) and monitoring the performance of health centres, level one hospitals, Health Centre Committee (HCC) and Neighbourhood Health Committees (NHC).

Health Centre Committee (HCC)

The HCC is composed of nominees from the Neighbourhood Health Committees (NHC). The health centre staff and representatives of other sectors, participate in the HCC. It is charged with supporting the management of health care in the catchment area. A major function of the HCC is to improve the accountability of the health centre staff to the community. It is consulted on the fees and on issues related to performance of the health centre staff. The HCC is supervised and monitored by the DHBs.

Neighbourhood Health Committees (NHC)

The community elects the Neighbourhood Health Committee (NHC) on the basis of their age and trust. The committee is composed of adult men and women who live in the area and are based in a household. They spearhead the development of community-based activities in health or related sectors. The NHC are supported and strengthened in their monitoring role by the HC Committee and the DHBs. The NHCs can exist at the health post and the health centre level. At the health centre level, the NHC is involved in financing issues and the development of action plans.

APPENDIX III – DESCRIPTION OF MoH/CPs POWER RELATIONS IN THE SWAp

Five phases can be clearly distinguished which reveal varying degrees of MoH/CPs relations since the inception of the health SWAp.

Firstly, the period **1991–1993** can be described as the conceptualization of the SWAp process and decentralisation of authority and responsibility from the centre to districts. During this period, political commitment, good will and confidence in the health reforms was high.

Secondly, the period **1993–1997** was the implementation era and several interviewees regarded it as *'health reforms at work'*. A lot of changes were initiated among them being the constitution/restructuring of institutions; adoption of new policies and legislature; development of systems (FAMS and HMIS); partial de-linkage of health personnel to CBoH; and creation of new partnerships. The introduction of pooled funding for districts was the other highlight of this period.

Third, during the period **1997–1999**, partnership problems were experienced and the development of the SWAp was ultimately affected. A change in Ministers and key policy-makers at MoH led to imbalanced relations with CPs. While CPs pointed out the lack of transparency and accountability, MoH felt that the CPs were placing too much pressure on it and that they were too close for comfort.

In the period that followed (**1999 to 2004**), the confidence of the CPs was restored resulting in the signing of the Memorandum of Understanding in 1999, strengthening of joint planning and reporting systems, and institutionalisation of the SWAp process within the MoH structure through the establishment of the SWAp secretariat in 2003.

The period **2004–2006** has seen a number of positive and negative developments in the SWAp. Key informants indicated that the decision making process in the SWAp further improved during this period in that the decisions that were adopted were more consultative and transparent. Several Informants were happy with the culture of taking down action points and decisions reached in SWAp meetings and following up on these. The indication was that 90% of the times, decisions reached on consensus were adhered to. If not, at least there was agreement on who was responsible.

APPENDIX IV – PARTICIPANT CONSENT FORM

1. Title of Research Project

A Critical Evaluation of the Sector Wide Approach Programming (SWAp) System in the Health Sector in Zambia

2. Purpose of the research

The study is being conducted as part of the requirements for a Masters in Public Health degree at the University of Cape Town, South Africa. The study will look at the impact that SWAp has had on the provision of health care in Zambia and the attainment of national health goals and objectives. Assessment of impact will be done by looking at the effectiveness of resource management, efficiency in the use of pooled resources, level of support/financial stability, and relational and collaborative processes. Furthermore, the study will also look at the degree to which SWAp has influenced equity in access and utilisation of services by level of healthcare. It is anticipated that the study will draw out pertinent experiences that will be used to inform policy on how to further improve the performance of the health system in Zambia.

3. Description of the research project

You have been purposively selected to participate in the study as a key informant owing to your know-how and vast experience with the Zambian health sector. In this regard, you will be asked specific questions on how you personally feel SWAps have impacted on the provision of health care in Zambia.

4. Confidentiality of information collected

All written and electronic transcriptions that will be obtained from you will be treated with utmost confidentiality and will only be seen by me and my supervisor. Your identity will not be disclosed in any draft or final report of the study nor will any specific comments be attributed to you.

5. Risks and discomforts of the research

There are no risks from participating in the research and neither are there any invasive procedures. Should you decide to discontinue with the interview and/or decline to answer certain questions, please feel free to do so.

6. Expected benefits

Though you will not directly benefit from the study, it is expected that the results of the study will be used to improve the operation of the health system in Zambia. A final report on the research findings will be availed to you as well as other participants, stakeholders and interested parties.

7. Contact person

Please contact me on mobile 095-833178 (Zambia) / +27-72-431-514 (Cape Town) or by e-mail kachansa@yahoo.co.uk for any other matter that you might wish clarified before and/or after the onset of the research.

Consent of the participant

I have read the information given above and I fully understand the meaning of it. I willingly offer to answer any questions concerning the study. By signing this form, I hereby consent to participate in the study and allow the researcher to interview me. I also understand that I am free to withdraw from the study at any time without penalty.

Authentication of the consent

_____ _____

Printed name of participant Signature

_____ _____

Interviewer's name (Print) Signature

A copy of this signed document will retained by the researcher while a copy will also be availed to the participant.

APPENDIX V – INTERVIEW SCHEDULE

Preamble
Please briefly explain what you understand by the Sector Wide Approach programming (SWAp) mechanism in the context of the MoH in Zambia.

For how long has the SWAp been in existence? Who organized it?

In your opinion, what were some of the specific objectives that necessitated the adoption of such a system?

Governance and Management
How is the SWAp governed? Are there any management/organizational structures in place? If so how are these implemented?

How do you as an organisation relate with the government in the implementation of the SWAp? Power relations, who drives the show?

Is there a legally binding document in place outlining how business should be conducted in the SWAp? If so, is this document(s) adhered to?

Membership and Participation
How many donors/stakeholders are currently involved in the SWAp? How many contribute to the expanded basket? How many are merely active participants in the SWAp coordination structures.

How do you deal with members that are merely part of the decision making process? Do these have a lesser voice in the meetings?

How effective is the decision making process in the SWAp?

Scope of the expanded basket and resource allocation
What facilities and range of health services are covered by the expanded basket? What services are excluded? Why?

How are the pooled resources allocated? In your view, is the allocation of resources by level of health care and programme adequate?

Is the SWAp addressing all the primary interventions as envisaged in the Basic Health Care Package?

Financing, Sustainability and Financial Management
What are the annual rate(s) of contribution by donor to the expanded basket?

How are the contributions made? Does this correspond to the pledged amounts as stipulated in the Joint Investment Plan?

What can you say about government's level of funding to the health sector? How committed is the government in meeting its pledges? What would you say about financial stability during the SWAp? Are there any mechanisms in place to avoid disruption of programme implementation in the advent of disputes?

Do you receive any financial or in-kind support from local agencies apart from external agencies?

Who manages the finances and what structures are in place to effectively manage the pooled resources? To what extent has the SWAp curbed corruption?

Quality, Utilization and Access
In you own view, has the SWAp led to improved quality of care? If so, how?

What impact has it had on the level and pattern of utilization of health services?

What impact has it had on access to health services?

Constraints, failures and areas of improvement
What do you think are the successful elements of a SWAp?

What are the key constraints and bottlenecks that you see in the SWAp? What are the areas for further improvement?

If you had more money to give the Zambian government as a grant, at what level of care and programme would you want it channeled? Why?

APPENDIX VI – UCT RESEARCH ETHICS COMMITTEE APPROVAL

UNIVERSITY OF CAPE TOWN

Health Sciences Faculty
Research Ethics Committee
Room E53-24 Groote Schuur Hospital Old Main Building
Observatory 7925
Telephone [021] 406 6338 • Facsimile [021] 406 6411
e-mail: preaward@curie.uct.ac.za

17 October 2005

REC REF: 373/2005

Mr C Chansa
Public Health and Family Medicine

Dear Mr. Chansa

A CRITICAL EVALUATION OF THE SECTOR WIDE APPROACH PROGRAMMING (SWAp) SYSTEM IN ZAMBIA

Thank you for submitting your study to the Research Ethics Committee for review.

Date Considered: 10 October 2005

Decision: Approved

It is a pleasure to inform you that the Ethics Committee has formally approved the above-mentioned study.

Please quote the REC. REF in all your correspondence.

Yours sincerely

PROF T. ZABOW
CHAIRPERSON

KBoard

APPENDIX VII – WRITTEN CONSENT FROM THE MINISTRY OF HEALTH, ZAMBIA

All correspondence should be addressed to the
Permanent Secretary
Telephone 253040/5
Fax 253344

In reply please quote

No. . . . . .

REPUBLIC OF ZAMBIA

MINISTRY OF HEALTH

NDEKE HOUSE
P.O.Box 30205
LUSAKA

8th November 2005

To Whom It May Concern

RE: A CRITICAL EVALUATION OF THE SECTOR WIDE APPROACH PROGRAMMING (SWAp) SYSTEM IN THE HEALTH SECTOR IN ZAMBIA

This is to attest that Mr. Collins Chansa, SWAp Co-ordinating Officer - Ministry of Health, has been granted due permission to conduct the above-mentioned study. The study is being conducted as part of the requirements for the award of the degree of Masters in Public Health at the University of Cape Town, South Africa. The study will cover issues relating to fair financing and health systems governance particularly the impact that SWAp has had on the provision of health care in Zambia and the attainment of national health goals and objectives. It is anticipated that the results of the study will provide best available evidence on the operation of the Zambian health care delivery system and how to further improve upon it.

Owing to your vast experience and know-how, Mr. Chansa has purposively selected you to participate in the study as a key informant. In this regard, I would really appreciate if you could accord him with all the necessary support. A final report on the research findings will be availed to you as well as other participants, stakeholders and interested parties.

Yours Sincerely,

Dr. Simon. K. Miti
PERMANENT SECRETARY
MINISTRY OF HEALTH